HOSPITALS

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JULY 1, 1957

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1. Bacala, J.C.: The Use of the Systemic Hemostat, Carbazochrome Salicylate, West J. Surg. *64*:88 (1956).

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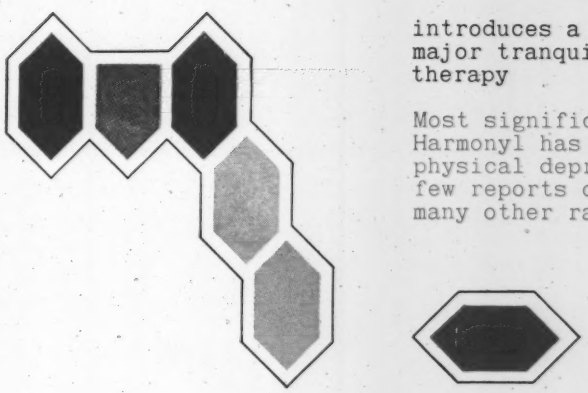

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References: 1. Communication to Abbott Laboratories, 1956. 2. Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, Journal Lancet, 76:389, December 1956.

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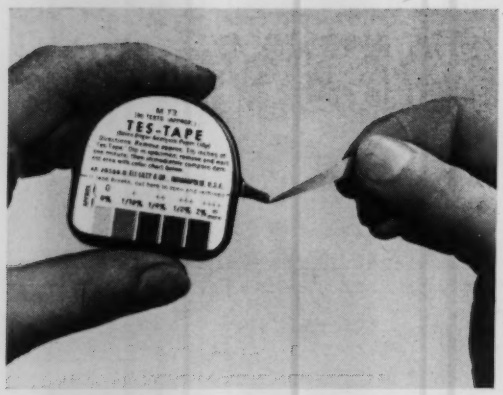

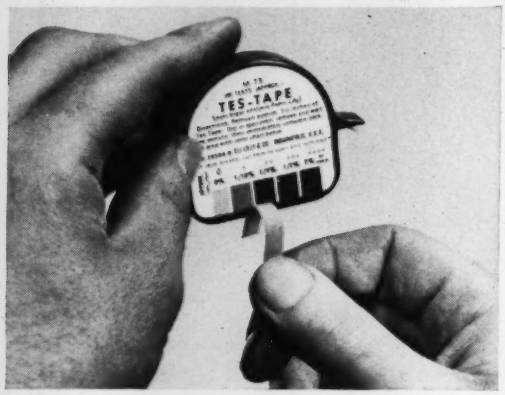

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cover

Informal conferences keep Superintendent Liala I. Johanson, R.N., (standing) of Lake Forest (Ill.) Hospital in close touch with members of the hospital's medical and paramedical staff. Here she talks over a problem with the hospital's part-time radiologist and pathologist. Picture story on page 45. Cover photograph by Robert McCullough. (Other picture credits on page 118.)

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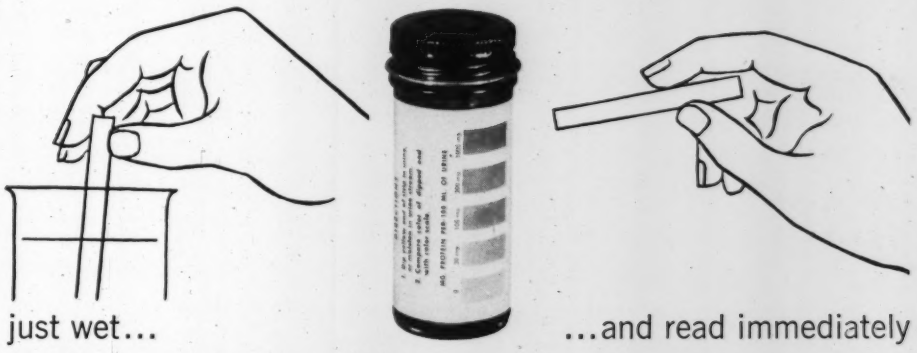

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(THROUGH JUNE 1958)

American Hospital Association
Annual Convention — September 30-October 3; Atlantic City, N. J. (Hotel Traymore; Convention Hall)
Midyear Conference of Presidents and Secretaries — January 27-28; Washington, D. C. (Statler Hotel)

American Protestant Hospital Association — February 11-13; Chicago (Morrison Hotel)

REGIONAL MEETINGS

(THROUGH JUNE 1958)

Maryland-District of Columbia-Delaware Hospital Association—November 18-20; Washington, D. C. (Shoreham Hotel)

Mid-West Hospital Association — June 4-6; Kansas City, Mo. (Municipal Auditorium)
New England Hospital Assembly—March 24-26; Boston (Statler Hotel)
Southeastern Hospital Conference—May 14-16; Miami Beach, Fla. (Hotel Fontainebleau)
Tri-State Hospital Assembly—April 28-30; Chicago (Palmer House)

STATE AND PROVINCIAL MEETINGS

(THROUGH DECEMBER 1957)

Associated Hospitals of Alberta—October 22-24; Edmonton (Provincial Auditorium)
Arizona Hospital Association — December 5-6; Phoenix (Hotel Westward Ho)
British Columbia Hospitals' Association—October 15-18; Vancouver (Vancouver Hotel)
California Hospital Association—October 31-November 1; Long Beach (Lafayette Hotel)
Colorado Hospital Association—October 10-11; Glenwood Springs (Hotel Denver)
Connecticut Hospital Association — November 13; Berlin (Connecticut Light and Power Company)
Idaho Hospital Association—October 21-22; Boise (Hotel Boise)
Illinois Hospital Association—December 5-6; Springfield (Abraham Lincoln Hotel)
Indiana Hospital Association — October 9-10; Indianapolis (Student Union Building, University of Indiana Medical Center Campus)
Kansas Hospital Association—November 14-15; Wichita (Broadview Hotel)
Mississippi Hospital Association — October 9-11; Biloxi (Hotel Buena Vista)
Missouri Hospital Association — October 31-November 2; St. Louis (Hotel Jefferson)
Montana Hospital Association—October 8-10; Billings (Northern Hotel)
Nebraska Hospital Association—October 17-18; Lincoln (Cornhusker Hotel)
North Carolina Hospital Association — August 9; Asheville (Battery Park Hotel)
Oklahoma Hospital Association—November 7-8; Tulsa (Mayo Hotel)
Ontario Hospital Association — October 28-30; Toronto (Royal York Hotel)
Oregon Association of Hospitals — November 4-5; Eugene (Eugene Hotel)
South Dakota Hospital Association — October 15-16; Sioux Falls (Sheraton Cataract Hotel)
Vermont Hospital Association—October 18; Pico Peak, Rutland (Long Trail Lodge)
Virginia Hospital Association—November 16-17; Roanoke (Hotel Roanoke)
Washington Hospital Association — November 6-7; Seattle (Olympic Hotel)
West Virginia Hospital Association — August 1-3; White Sulphur Springs (Green Briar Hotel)
Wyoming Hospital Association—October 17-18; Casper (Memorial Hospital of Natrona County)

(Continued on page 114)

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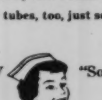

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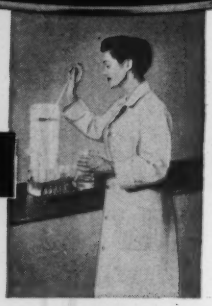

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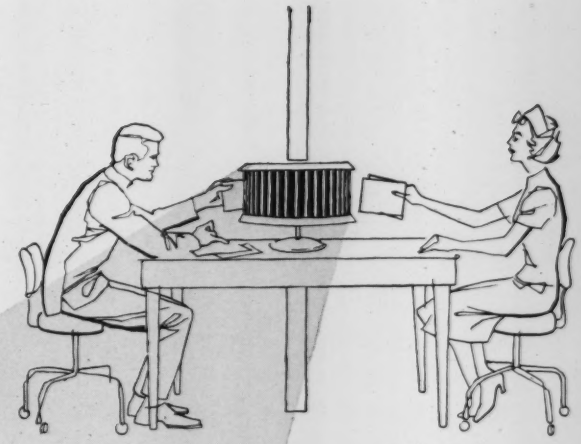

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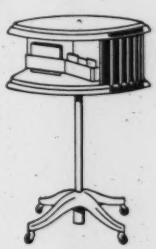

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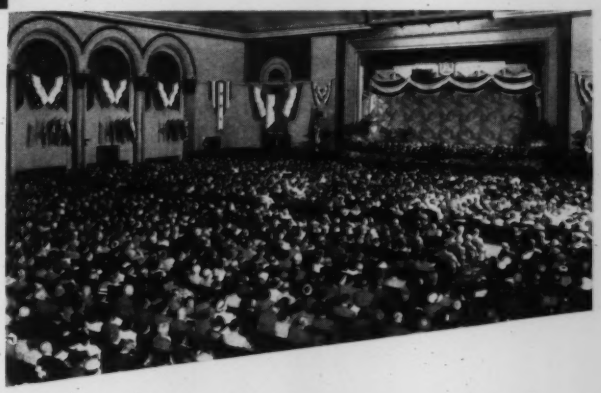

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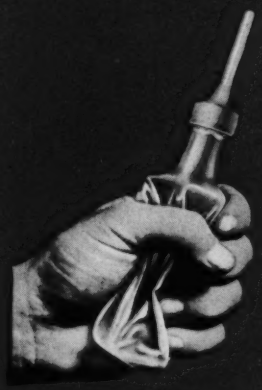

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Standard vs Disposable Unit Enema; Rainer, W. G. and Lee, B., Hospitals, 31:50, January 1, 1957.

(1) Swinton, N.W., Surg. Clin. No. Am., 35:813, 1955

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Wayne B. Foster, administrator of a 130-bed hospital in southern Ohio for the past seven years, reports "Committees Are the Best Framework for Getting Medical Staff Work Done" in small as well as large hospitals in this issue of the Journal (p. 32). Mr. Foster came to Holzer Hospital and Clinic, Gallipolis, Ohio, from University Hospital, Columbus, where he had served as assistant administrator and director of personnel and public relations.

During World War II he served as captain in the U. S. Army and received the Purple Heart with two clusters and other citations.

A member of the American College of Hospital Administrators, Mr. Foster received his bachelor's and master's degrees in business administration from Ohio State University. He is currently serving as president of the Ohio Hospital Association.

Glenn A. Fisher, administrator of a 45-bed New England hospital where many personnel perform duo-functions, speaks from personal experience in stressing the importance of coordinating plant layout and personnel functions in his article, "Divided Duties Demand Unified Plant Layout", (p. 48). Mr. Fisher came to Nanticoke Memorial Hospital, Seaford, Del., in 1951, from the Fairmont (W. Va.) General Hospital where he served as credit manager and administrative assistant for four years.

After taking premedical courses at Fairmont (W. Va.) State College and at West Virginia University, Mr. Fisher served as a surgical technician in the U. S. Army.

Active in state and regional hospital association work, Mr. Fisher is a trustee and the immediate past president of the Maryland-District of Columbia-Delaware Hospital Association.

Dabney P. Gilliland, administrator of General Hospital, Greenville, Miss., writes on medical staff organization (p. 57) for this smaller hospital issue of the Journal. Mr. Gilliland came to Greenville three years ago after completing an administratorship at Franklin County Memorial Hospital, Meadville, Miss.

After receiving his master's degree in hospital administration at St. Louis University, Mr. Gilliland served his administrative residency at Mercy Hospital-Street Memorial, Vicksburg, Miss.

He is a nominee in the American College of Hospital Administrators.

Joseph A. Geraghty, author of "Machines Are the Drudges in This Inventory Control System", (p. 68), has served as comptroller of Mary Immaculate Hospital, Jamaica, N. Y., for the past 11 years. During Mr. Geraghty's tenure the hospital transferred to machine accounting and introduced a work simplification program.

Mr. Geraghty also serves as assistant to the administrator of the hospital as well as a consultant on accounting systems and procedures for several other New York and New Jersey hospitals.

A graduate of Pace College, New York City, Mr. Geraghty took specialized hospital courses at Columbia, Rutgers and Indiana Universities.

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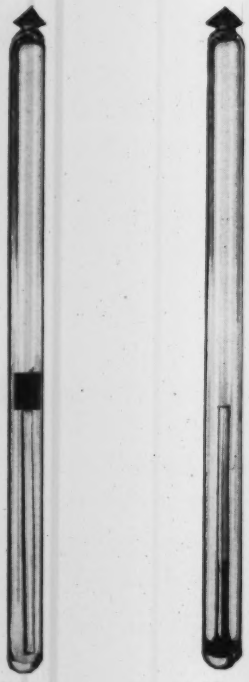

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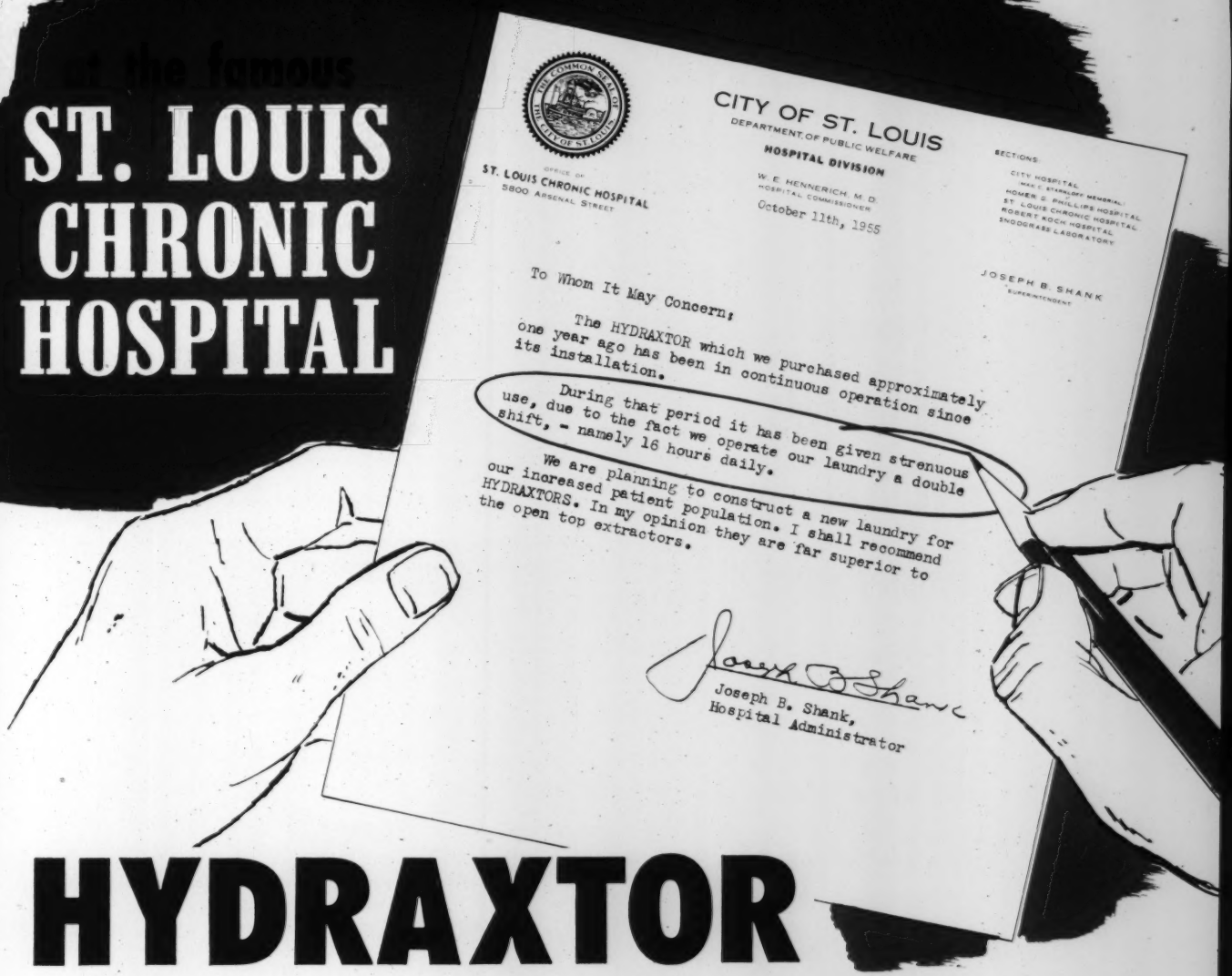
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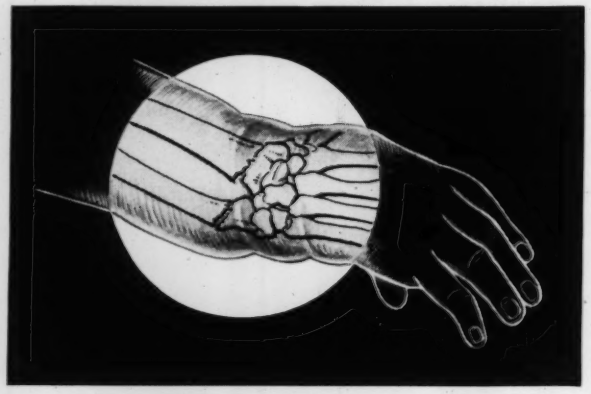

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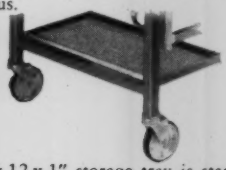

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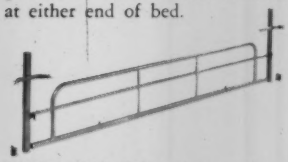

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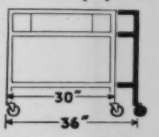

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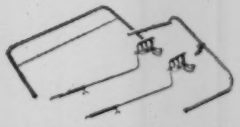

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Head piece removed. Bed permits access for eye work or other activities at the head area.

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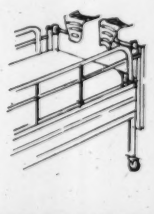

No. 1484RG 30" WIDTH
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$2.8 BILLION APPROVED BY SENATE FOR HEW—The Senate has voted to approve an appropriation of $2.8 billion for the coming year's activities of the Department of Health, Education, and Welfare.

In doing so, the Senate agreed to an appropriation figure $38 million higher than that approved by the House. This entire sum was allocated to the budget of the National Institutes of Health for medical research.

Even with the increase, however, the amount approved was $66 million less than the administration had outlined in its budget request. (Details p. 99.)

LIMITED IMMUNITY RULINGS OVERTURNED IN NEW YORK STATE—The New York State Court of Appeals has handed down a ruling in the case of Bing v. Thunig that eliminates hospitals' limited immunity from negligence suits. (Details p. 101.)

108 TREATED AT HOSPITALS AFTER FARGO, N.D., TORNADO—Ten persons were killed and 108 were injured severely enough to require treatment at hospitals when a tornado struck Fargo, N.D., on June 20. Forty-one of the injured were hospitalized.

None of the area's hospitals were damaged; they put their disaster plans into effect when the storm struck. Fargo does not have an area-wide plan. Telephone communication was disrupted by the storm, but local radio and television stations cooperated with the hospitals to alert staff members and secure blood donors.

- At Fort Bragg, N.C., 47 National Guardsmen were injured by lightning bolts on June 19. All 47 were admitted to the post hospital suffering from shock or burns, although none appeared to be seriously hurt, an Army spokesman said.
- A capsule review of recent disasters which have affected hospitals begins on p. 109.

STUDY SHORTAGE OF X-RAY PERSONNEL: SAGE—David C. Sage, R. T., in his presidential address before the Second International Convention of X-ray Technicians said that there is a shortage of qualified technical personnel and that a solution to the shortage must be found. (Details p. 102.)

SCHOOLS ANNOUNCE ADMINISTRATIVE RESIDENCIES—Graduates of the academic programs of schools of hospital administration are entering their administrative residency programs, the schools have reported. Lists and photographs of some of the 1957 residents are contained in this issue of **HOSPITALS**, beginning on p. 104. Remaining residents will be listed in the July 16 issue of this Journal.

RHODE ISLAND PAYS HOSPITALS FOR INDIGENT CARE—The Rhode Island General Assembly has appropriated $626,700 to partially reimburse five voluntary hospitals that make their facilities available to public ward patients.

ILLINOIS ASSOCIATION PROPOSES AID TO NURSING SCHOOLS—In order to relieve the financial burdens facing hospital schools of nursing in Illinois, the Illinois Hospital Association has made the following suggestions to the state legislature:

- That the state grant a subsidy, $300 per student per year, to all voluntary Illinois hospitals operating schools of nursing.
- That the grants be made with the intent of relieving the present financial burden on the sick patient, and (a) preventing the closing of more schools; (b) encouraging schools to expand, and (c) encouraging new schools to open.
- That funds be administered by the State Department of Public Health, as the agency responsible for licensing hospitals.

Such a program, the association stated, would involve an expenditure of approximately $2 million per year. While the subsidy would not cover the schools' full cost, the association stated that "such a program would have the effect of encouraging more effort to get supplementary financing from the local community and stimulate continued improvements in our educational programs."

NURSING SHORTAGE RECOMMENDATIONS MADE BY NEW YORK ASSOCIATION—Establishment of a National Commission on Nursing Service and Education has been advocated by the board of trustees of the Hospital Association of New York State. The commission's function would be to "study the problems created by the nursing shortage."

The board also recommended: "That the state hospital association call attention to the fact that the two-year associate degree programs as presently being conducted in several experimental programs in the state are far more expensive than the three-year hospital school program because no credit can be given for student services; that the elimination of practically all practice work results in a graduate who is not capable of carrying full responsibilities in clinical patient care; and that the incentive to recruitment that is present in hospital schools will not exist in college schools. If these two-year associate degree programs continue, however, an additional year of clinical internship should be required before graduation."

In the same area, it was recommended "that the state hospital association encourage the directors of hospitals operating three-year hospital schools of nursing throughout the state to form an organiza-

Worth Quoting

". . . The marked absence of research study on the organization and the provision of services [in the National Health Service] is a gross lack closely related to the efficiency of training for administration in the field of medical care. Systematic research and experiments in medical care are as badly needed as in bacteriology or in surgery. . ." —Dr. O. L. Peterson, A Study of the National Health Service of Great Britain, *quoted in* Hospital and the State, I, *the Acton Society Trust.*

tion of such schools in the state, and that this organization unite with a national organization of hospital schools of nursing, and that other states be encouraged to take similar action."

Other recommendations made by the board were that:

- The New York association reintroduce a bill to permit student nurses to volunteer for hospital work during their free time, within the scope of their training and ability, and under supervision, if their health and their school grades are satisfactory.
- The state association urge the state group which awards student nurse scholarships to take the student's need into consideration and that in granting scholarships to prospective student nurses the emphasis be placed on nurses entering three-year schools of nursing as distinct from collegiate schools.
- The state group express itself to the effect that accreditation of hospital schools of nursing should be accomplished under the auspices of the Joint Commission on Accreditation of Hospitals, with full representation of all agencies.
- The state association urge the Practical Nurse Association of New York State to maintain the practical nurse training course at one year.

PENNSYLVANIA COMMITTEE MAKES PERSONNEL POLICY RECOMMENDATIONS—It has been recommended that western Pennsylvania hospitals pay a monthly starting salary of $265 to general duty nurses.

The recommendation was made by the Personnel Committee of the Hospital Council of Western Pennsylvania. The committee also recommended that head nurses receive $300 per month and supervisors $345 per month as starting salaries. All salary figures were computed on the basis of a 40-hour week.

In making the recommendations, the committee suggested that "current adjustments of nurses' pay be accompanied by appropriate adjustments for other employees, especially those in the lower salary brackets. In particular, [the] committee recommends that the starting salary for the licensed practical nurse be continued at 70 per cent of the starting salary for the registered general duty nurse."

It was further recommended that there be six salary increments at six month intervals for: general duty nurses—$5 per month; head nurses and supervisors—$7.50 per month.

Other salary increases are to be made on the basis "of individual evaluation of exceptional or meritorious service to the hospital" and in no case is the "maximum salary for any position [to] be more than 30 per cent above the starting salary."

The committee recommended that hospitals allow their employees seven paid holidays per year and that registered nurses with one year of service receive paid vacations on the basis of: general duty nurses—10 working days; head nurses and supervisors—15 working days. Five additional working days of paid vacation were to be provided for nurses after five years of continuous service in the same hospital.

Part-time nurses, it was recommended, are to receive a straight hourly rate of $1.65 without any vacation, sick leave, holidays, or other benefits.

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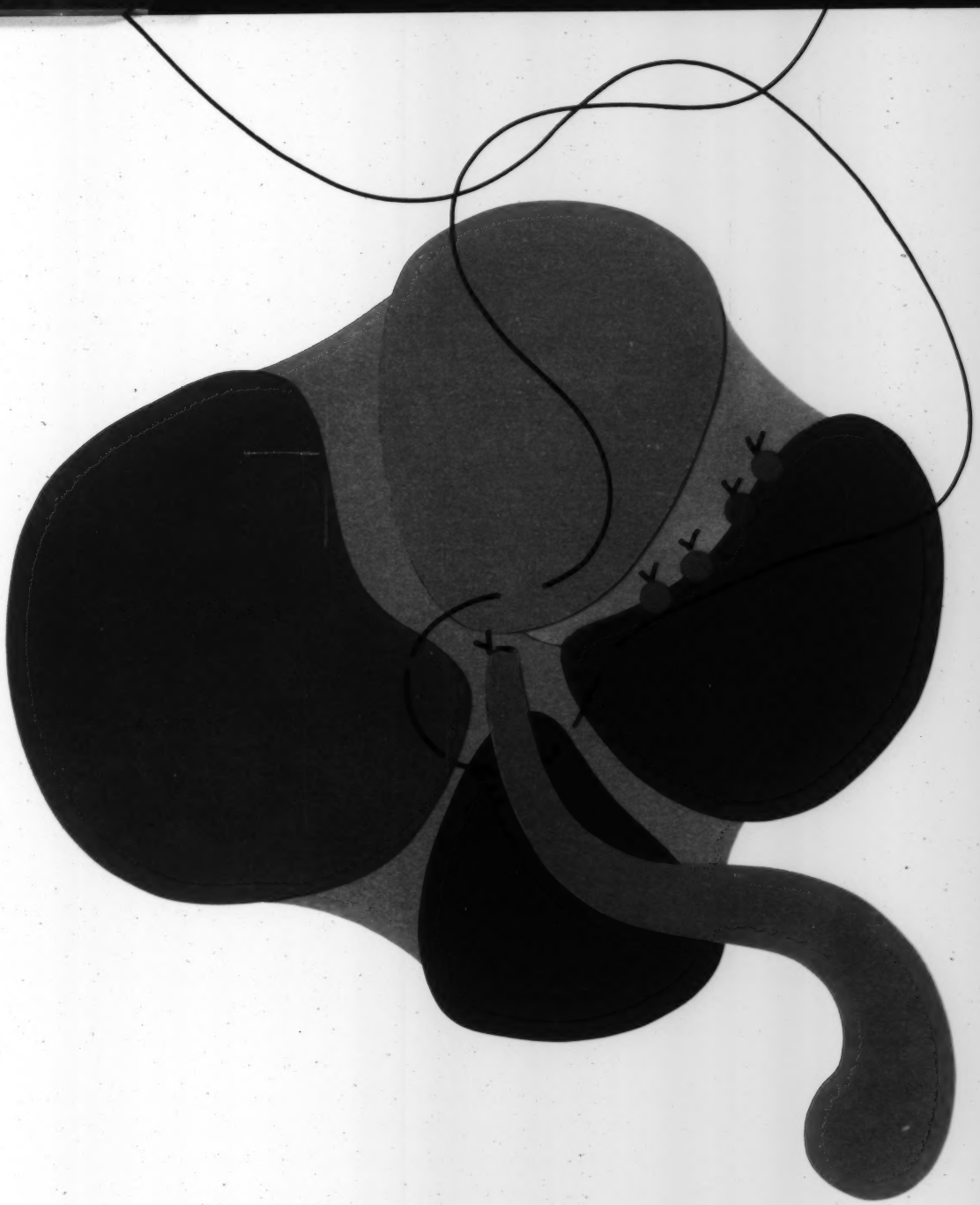

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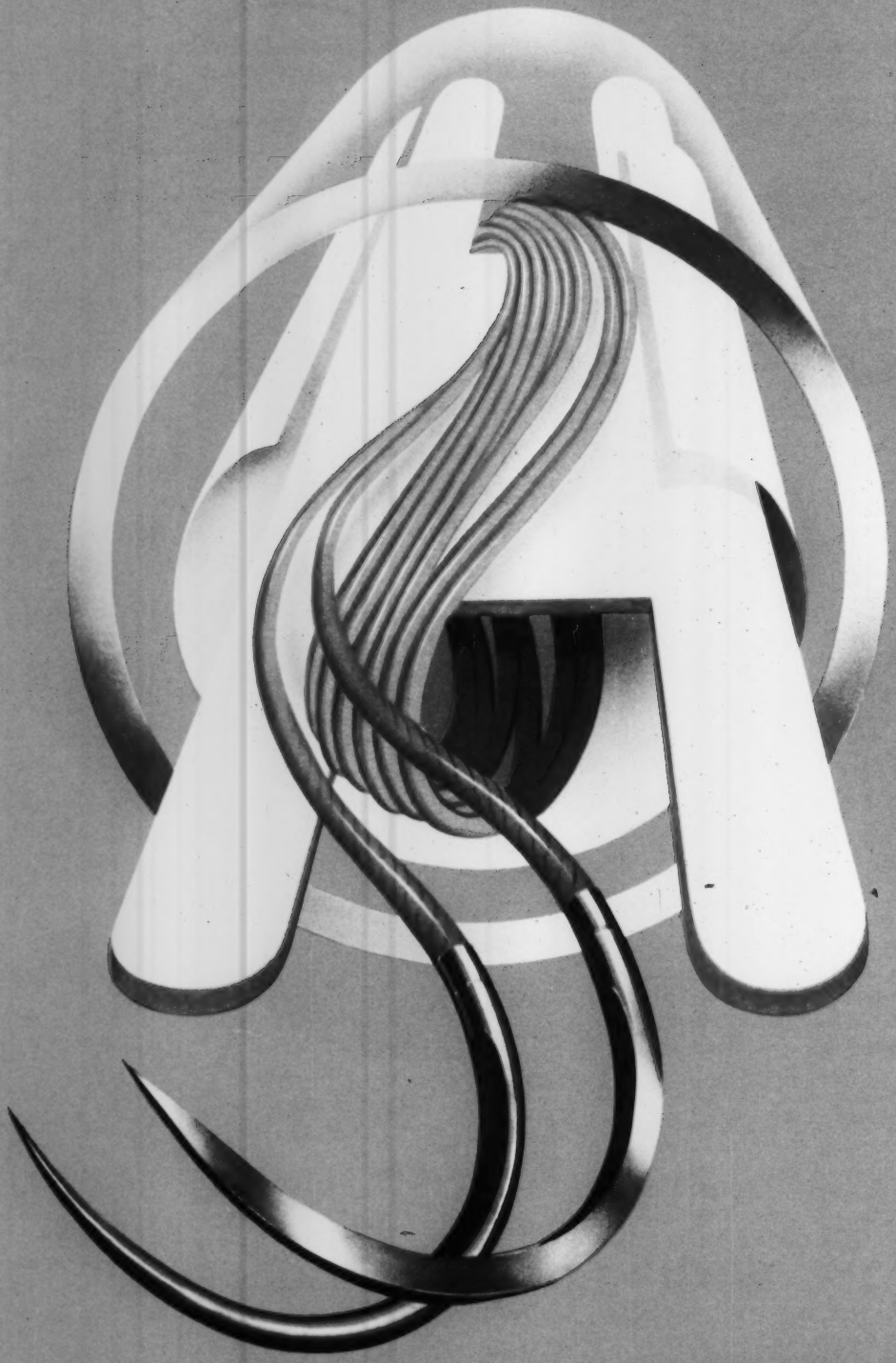

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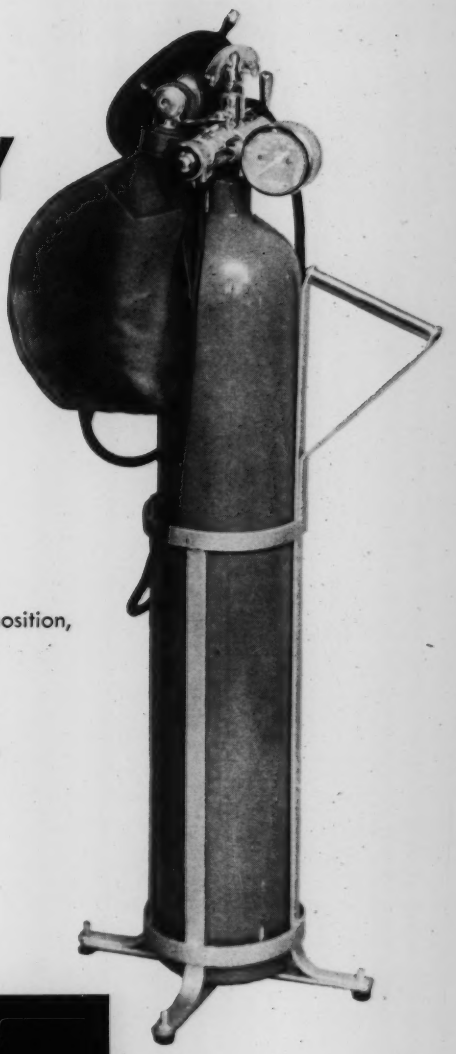

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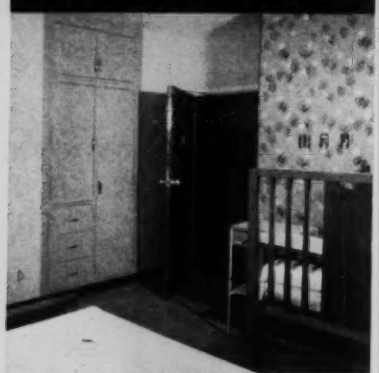

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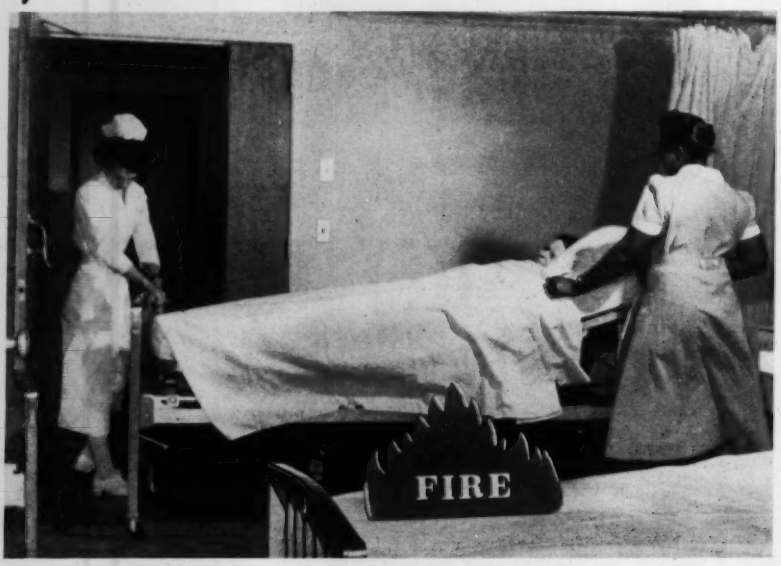
opinions and ideas



A SIMULATED fire, made of wood, triggers fire drills at Highland View Hospital, Cleveland.

* * *

Cleveland hospital finds 'fire' sign improves drills

To bring more realism into fire drills at Cleveland's Highland View Hospital, the hospital's safety program committee developed a "fire" sign to provide a spontaneous mechanism for initiating fire drills in any part of the hospital's 12 buildings. Administrator R. W. Marquand reports that the use of this sign has greatly improved the hospital's fire training program.

The committee member who places the "fire" is the only person who knows where the drill will be held. The same member times the drill and records are kept on all aspects of the drill.

When the "fire" is discovered, patients are immediately moved from the "fire" area; the personnel pool forms; the fire brigade moves in on the "fire"; the "fire-affected" area is closed down; and all elevators are controlled and at the floor ready for evacuation.

These drills are held every week or two, never following any floor, building or time schedule. A sectional drill takes approximately 6 to 8 minutes, while a total hospital drill averages 25 to 30 minutes. —RAY B. GOETZE, *administrative assistant, Highland View Hospital, Cleveland.* ■

Surgery-admitting hookup saves doctors', clerks' time

The installation of a direct telephone line between the admitting department and the operating room at The Doctors Hospital, Seattle, has proved to be efficient and have great public relations value for the hospital. Furthermore, the problem of having persons scheduled for surgery and not for admission has been eliminated.

When a doctor calls the operating room to schedule an operation, he is asked to talk to the admitting department at the same time and this is done by momentary automatic switching. The automatic switching is done directly from the operating room telephone and does not have to go through the hospital switchboard.

Prior to this installation the admission office would often find names of persons on the next day's surgery schedule who were not in the house or on the room reservation list. Occasionally, there were as many as six of these cases in a single day.

Before the direct lines were available between surgery and admitting, the admission clerk had to verify the operating room schedule by telephone and frequently had to make calls to doctors' offices as well as to patients. This procedure was time-consuming and

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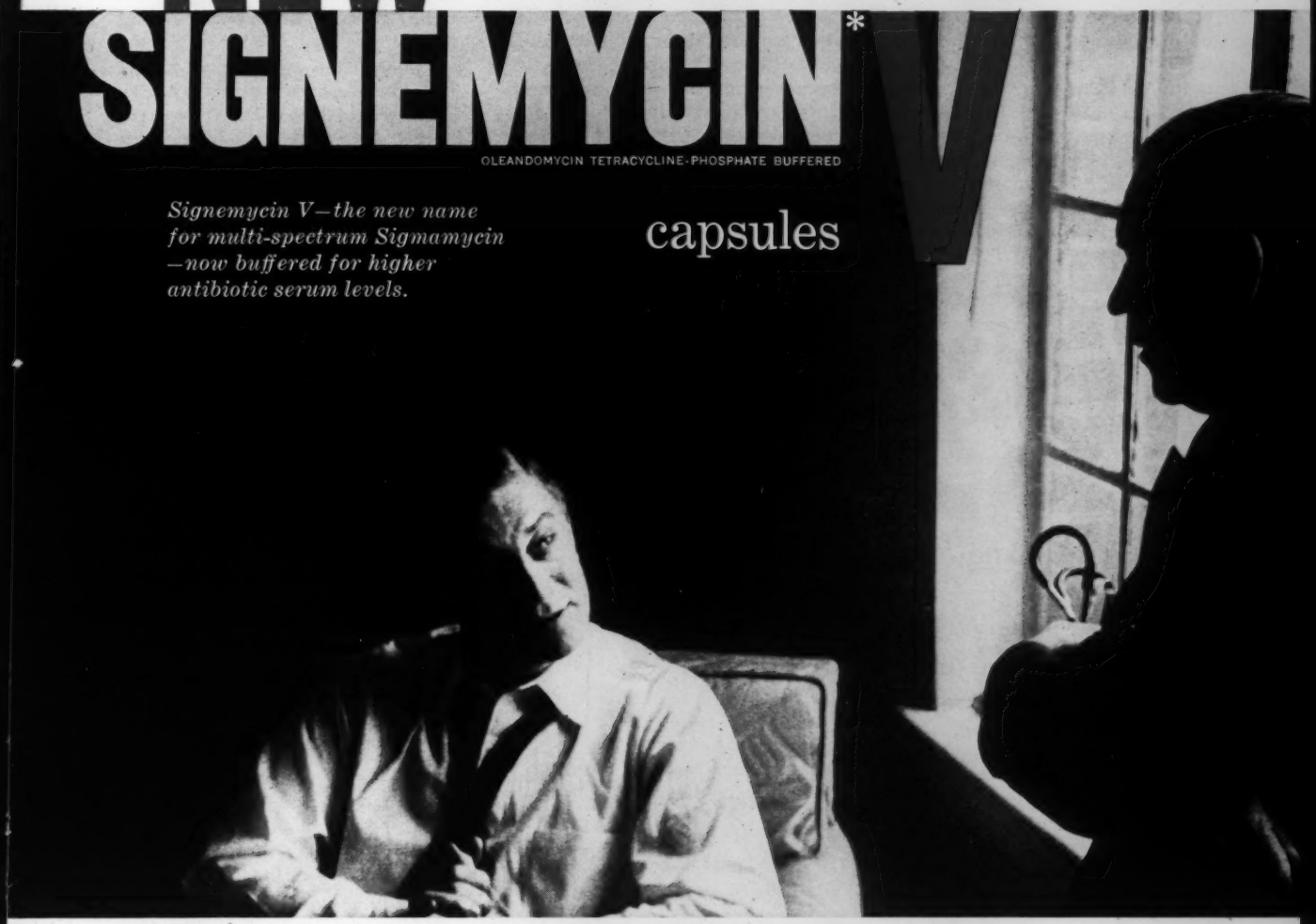

New added certainty in antibiotic therapy —particularly for that 90% of the patient population treated at home or office where susceptibility testing may not be practical.

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Division, Chas. Pfizer & Co., Inc.

very annoying to members of the medical staff. This simplified procedure also has made the control of beds easier.

Under the new system the surgery nurse presses the hold button and an intercommunication button on her telephone. This causes a continuous ringing in the admitting office until the clerk answers the intercommunication call. Surgery nurse then tells the admitting clerk the doctor's name and the extension number he is on. The admitting clerk merely presses the corresponding extension button on her telephone to take the doctor's call and to make the room reservation.

This system saves the doctors' time for they can now complete their scheduling in one call. It also saves the admitting clerk's time because there is seldom a discrepancy between surgery schedules and the room reservation list. From the public relations standpoint, this new procedure spares the hospital the embarrassing situation of having a surgical patient arrive at the admission office only to find no bed is available for him.

This idea was the result of the suggestion of the admitting department supervisor and the operating room supervisor. They worked out the details of the plan with the telephone company. Although there was an apparent direct cost of some size involved, the time saved appeared to more than compensate for the expenditure. Time has proved this to be so.

—ROBERT F. BROWN, M.D., *director, The Doctors Hospital, Seattle.* ■

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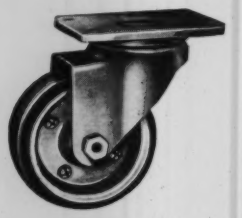

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Develop booklet to guide employees during transition

How to orient effectively 1,000 employees to a 10-story addition was one of the problems that recently faced the administration of the Milwaukee (Wis.) County Hospital. The administrative staff solved the problem by preparing a 28-page booklet entitled, *Your Guide to the New Milwaukee County Hospital.*

The hospital felt that since employee time is the most costly aspect of hospital operation, "lost" personnel, such as an attendant taking a patient to the wrong wing for an x-ray, would be reflected in the total picture of management economy, if multiplied by only a few instances.

Although notices of building progress and changes were issued regularly, it was felt that some form of directory for the employees would help to personalize and visualize the transition for them. Accordingly, a booklet was developed to give each individual a personal reference to services offered and a concise guide to locations and to provide an attractive memento for personnel for this milestone in the hospital's history.

The handbook is strikingly presented in red, black and white. The cover features a reproduction of Milton Horn's original sculpture for the new entrance, which symbolically depicts the healing arts. An isometric sketch of the grounds and buildings of the hospital center and a half-tone of the main building are also included.

Simplified plans of each floor are featured with numbers designating various areas. A key at the

(Continued on page 114)

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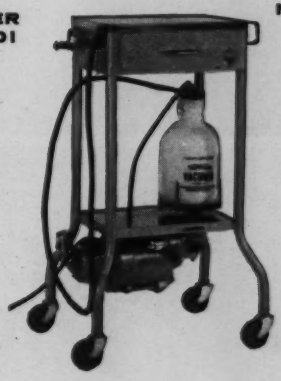

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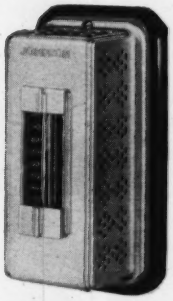

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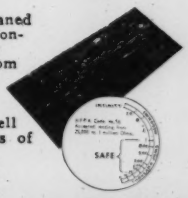
All field tests were made with strict observance to these requirements. Safe readings were maintained by simple, proper treatment and maintenance procedures using Hillyard Conductive Floor Cleaner exclusively.

The panels to the right show the great variance in Ohmeter readings between conductive floors cleaned with ordinary soap type cleaners as contrasted with the same floors cleaned with Hillyard Conductive Floor Cleaner.

The panel shows how destructive insulating film can easily be built up to destroy conductivity with Ohmeter readings well above the accepted standards.



The panel—cleaned with Hillyard Conductive Floor Cleaner, free from any insulating film, delivers safe readings well within standards of safe practices.

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service from headquarters

Oxygen safety measures

We would like information regarding recommended safety standards for the use of oxygen and oxygen equipment from a fire hazard standpoint.

It should be noted that oxygen itself is not an explosive gas. It does however accelerate the burning of combustible material to a high degree. For this reason, all sources of ignition which might set fire to bedding, etc., should be carefully controlled in any room in which oxygen is administered.

Assuming the possibility that the entire building might, at some time, contain an oxygen rich atmosphere, a fire, once started, could burn with such intensity that the ceiling would become ignited and the fire thus progress throughout the entire building. Wood construction of floors and ceilings increases this hazard and the installation of an automatic sprinkler system should seriously be considered as a safety measure. Other safety precautions would preclude the use of any material or equipment which might serve as a source of ignition and, of course, limiting smoking to rooms or areas where no oxygen could be present.

If you plan to use a piped oxygen system, we suggest that you obtain the pamphlet, *National Fire Protection Association Bulletin No. 565,* Standard for Nonflammable Medical Gas Systems. Section 5 of this bulletin concerns safety when using oxygen tents. The bulletin is available from Association headquarters for 35 cents.

—GERALD A. WEIDEMIER

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

Purchasing agents' aids

We are now training a new purchasing agent. He needs a variety of information about the items he is buying. Where can he obtain informative material on linens, china and foods in particular, and other staple items which he will have to evaluate and buy?

There are several sources of information available to assist your purchasing agent. Regarding food, the American Hospital Association has published the following:

Manual of Specifications for Canned Fruits and Vegetables; Food Service Manual; Readings in Hospital Dietary Administration, and the dietary section of this Journal. (If you do not already have copies in your hospital, they are available from the Association.)

The Department of Agriculture has a marketing service which will assist consumers in developing specifications for meats, poultry and produce, according to the in-

dividual hospital's needs. In some instances they will also inspect purchases prior to delivery to insure that the standard specification is being followed. For further information concerning this service, write to the Department of Agriculture, Washington 25, D. C.

Federal specifications are available on most of the usual hospital items. The *Index of Federal Specifications and Standards* is available for $1.75 from the Government Printing Office, Washington 25, D. C. These specifications provide pertinent information on the individual items and are kept current by periodic review. The hospital purchasing agent should find these specifications an excellent guide for preparing his own specifications. In addition, the government specifications usually include testing and sampling procedures adaptable to hospital use.

A list of commercial standards and simplified practice recommendations which have been developed through the cooperation of the Department of Commerce are also available from the Government Printing Office.

A good guide for the purchase of linens is the *Hotel Textile Purchasing Guide* published by the American Hotel Association in 1956. It is available from them at 221 West 57th Street, New York 19, for $7.50.—JACK D. DILLMAN

Accreditation booklet

Does the American Hospital Association have any material on accreditation suitable to give to the patient and the hospital visitor?

"On Guard For You," a 12-page 3½ x 6 inch booklet published by the Association, is designed to explain the significance of accreditation. It describes clearly and succinctly the Joint Commission on Accreditation of Hospitals and its requirements in regard to patient care, equipment and facilities. This attractive booklet will help accredited hospitals to capitalize on the public relations aspect of accreditation. "On Guard For You" can be imprinted with the name of the hospital.

(Quantity prices are: 1-499 copies, $8 per 100; 500-900, $6.80 per 100; 1,000 or more, $6 per 100.)

—DANIEL S. SCHECHTER

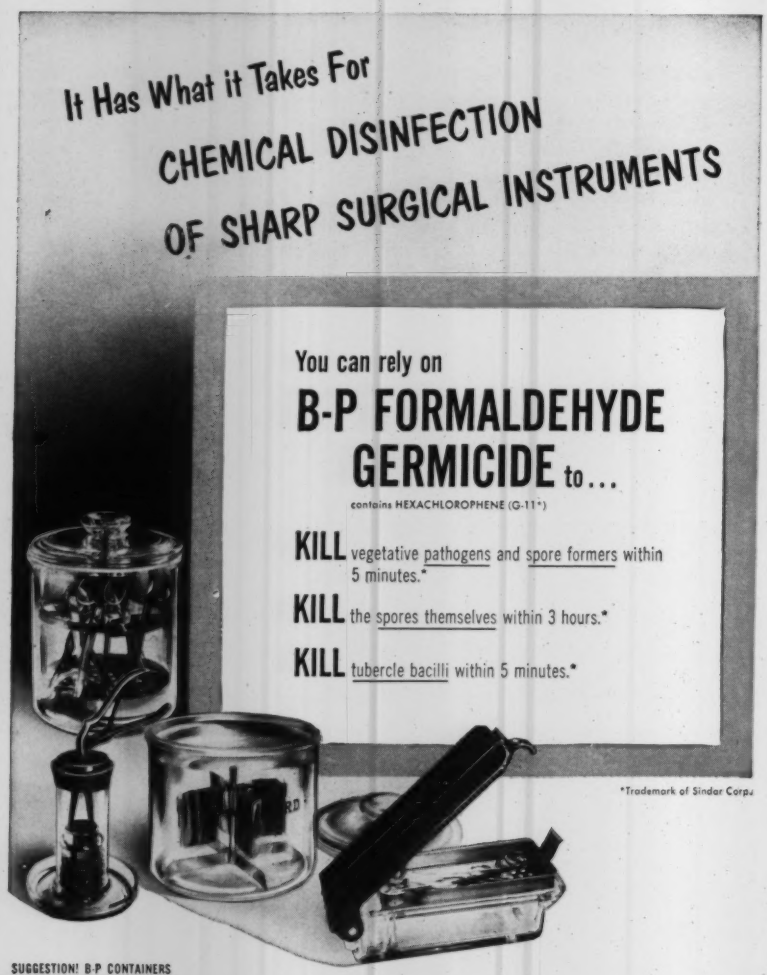
Local anesthesia

Is it proper for local anesthesia to be given without a nurse anesthetist or an anesthesiologist standing by or is their presence indicated only when so ordered by the surgeon?

There is no categorical answer to this question. Under most circumstances local anesthesia is used for relatively minor procedures and I believe it is customary for surgeons to administer this without an anesthesiologist or anesthetist standing by. Common examples of this are the removal of small and relatively superficial lesions, the suturing of small wounds or the simple low ligation of a varicose vein.

Situations in which a second physician or nurse anesthetist should be available would be those in which expert assistance might become necessary which could not be given by the operating surgeon.

Perhaps a committee of your medical staff might draw up suggested guides of procedure which after review and modification might be formally adopted. Such a committee should include an anes-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thetist as well as a surgeon. If you do not have an anesthesiologist or anesthetist on your staff, it might be well to ask one of the anesthesiologists in the area to consult with your committee.

—SARAH H. HARDWICKE, M.D.

Pediatric receiving unit

We understand that some hospitals have an admitting officer who examines and observes children before they are assigned to a permanent service in the hospital, even when the private pediatrician is fairly certain of the diagnosis.

We are interested in setting up such a receiving unit and would like to know of any particular requirements, equipment, etc., that others have used.

A number of hospitals do have a procedure for a check of all incoming pediatric patients in the emergency room or other admitting area of the hospital before these patients are permitted to go to a children's patient unit. This is primarily for a check on possible infectious disease, either one of the common communicable diseases of childhood, or an upper respiratory infection. This is done even though the patient is sent in by a senior pediatrician because there is often a lapse of time, or the pediatrician may not have actually seen the child prior to arranging admission. Transmission of chicken pox or measles to another inhospital patient could be very serious in some instances.

Such a receiving unit should have proper crib or bed facilities for children and a place for the parent to sit with the child. Usually it is necessary to provide for a stay in this unit of an hour or two in case the examining pediatrician is urgently needed elsewhere when the patient arrives.

Some hospitals have provided for admission to an isolation unit in which the patient remains for a period of 48 hours or longer before admission to a regular division. This does not take care of the problem of communicable disease with a longer incubation period than this as is true of many of the childhood diseases, but on occasion this device may be useful. It is recommended and customary for admissions to premature nurseries of infants born outside the hospital.

—SARAH H. HARDWICKE, M.D.

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HOSPITALS

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editorial notes

—how small is small?

The term *small hospital* has been the object of considerable discussion through the years. How small a hospital must be to be small has proven to be as difficult to determine as how big a hospital must be to be big.

The bed index has often been used. Hospitals of less than 100 beds, for example, usually find themselves characterized as *small*. But such a definition is based on convenience rather than accuracy. There is little reason to expect that the problems and personality of a hospital of, say, 90 beds are significantly different than those of a hospital with 110 beds.

Services seem to provide even less precise help than bed size. Many relatively small hospitals have embraced the health center concept and provide their communities with a variety of educational and medical services that compares favorably with that found in larger institutions.

Perhaps it is staffing that identifies the smaller hospital. The administrator of a smaller hospital has only a few, if any department heads. Most of them, like himself, switch titles and duties at the addition of a hat.

This kind of management produces different problems than those found in most larger hospitals. Some of these problems are dealt with in this issue of our Journal, which is concerned primarily with the medical and paramedical aspects of smaller hospital operation. Proper organization and administration of these areas can help the smaller hospital fulfil its full responsibilities.

—forewarned is forearmed

The president of the Association, Dr. Albert W. Snoke, was interviewed by the press during the course of one of the recent regional hospital conventions. He cited the study by Ray E. Brown on hospital costs. Dr. Snoke said he concurred with this analysis and with the calculation that costs were likely to increase at an annual rate of approximately 5 per cent.

An objection was raised that this prediction would increase public anxiety over costs. A preferable approach, it was argued, was to spread, as constantly and widely as possible, the story of what the public now gets for its hospital dollar.

Actually, both stories need to be told. It is better to inform the public about the probable rise in costs before the fact. Doing it before the event makes it possible to couch the story in the form of an explanation. After the fact, the same story becomes, not an explanation, but a defense.

It is important that the public fully appreciate the fact that there is a price tag on the improvements in hospital care. It is a simple matter to cut hospital costs—just cut services and quality of service. But this is not what the public wants nor what doctors nor hospitals want to deliver.

We can argue that improvements in hospital care have not been so costly as they appear on the surface—through reduced stays and earlier return of the wage earner to his bench. But, the argument of shortened stay and quicker rehabilitation is not going to be so persuasive in the near future. Brown reasons that we are rapidly approaching the irreducible minimus of patient stays, that patients cannot count on shorter stays offsetting much, if any, of the increased cost per patient day.

We must, therefore, forewarn the public that costs are going up. We must emphasize that the public wants the best in medical care; that there is a price tag on it, and that it is worth the price.

There is a natural tendency to ignore the dollar sign when we are talking, or writing, or thinking about such things as advances in medicine. But regardless of the method of payment the dollar sign is there. To shrug it off, before the fact, as cheapening a great humanitarian endeavor is to invite trouble when it comes time, after the fact, to pay, as someone eventually must. This trouble could, by exacerbation, defeat our efforts to give the public what it wants—the best possible in medical care. The way to avoid the trouble is to take the public into our confidence.

medical and paramedical aspects of

the smaller hospital

no matter how small the hospital –

committees are the best framework for getting medical staff work done

by WAYNE B. FOSTER

Functions of the medical staff can be performed best in almost every hospital — regardless of size — through committee action, this author believes. In a survey conducted especially for this article, the author found that problems in the field of medical staff organization seem to be most pronounced in smaller hospitals. This, he believes, may be due to the fact that early writings on hospital administration disregarded the matter of staff committees in establishing model bylaws for smaller hospitals.

ONE OF THE most notable events in the growth of modern medicine in the past few years has been the increase in quality of medical care resulting from the efforts of the Joint Commission on Accreditation of Hospitals.

Of interest here is that area related to staff functions. The medical staff and hospital conscientiously concerned with insuring the quality of their medical care will strive to attain and then retain accreditation. Fortunately for the patient, most of them are doing so. The commission has set minimum standards that are neither arbitrary nor rigid. Their achievement is voluntary but they serve as a constant challenge to hospitals and medical staffs not only to meet but to exceed them.

Accredited or nonaccredited, satisfied with minimum standards or striving for further improvement, it appears from a recent survey* that a large number of hospitals are having problems in the field of medical staff organization. Small hospitals (100 beds or less) seem to have the most problems of this kind.

Our concern here then is:

1. To delineate the functions of the staff and the purposes of the committees appointed from it.

2. To determine how to get the work of the committees done.

3. To note where possible, any differences that may exist in the practices and procedures of hospitals of less than 50 beds and those having from 50-100 beds.

4. To determine if their application would vary in profit and nonprofit hospitals. Wherever possible, the principles of scientific management will be applied in defining the problems and in seeking their solutions.

COMMITTEES ONCE DISREGARDED

That problems exist in some hospitals may be due to the fact that early writings in the field of hospital administration disregarded the matter of staff committees in the hospital of 50 beds and under in establishing model bylaws for their organization and operation. They apparently assumed that in such institutions the staff would act as a whole on all matters as contrasted with the appointment of various standing committees in larger hospitals.

The JCAH, in an effort to avoid a double standard, has established certain basic requirements for the organization of the medical staff and its committees regardless of the number of beds or the numerical size of the staff. They hold that the complexity of committee organization depends upon the size and cooperation of the medical staff of the individual hospital.

The commission recognizes that

Wayne B. Foster is administrator of Holzer Hospital and Clinic, Gallipolis, Ohio.

*conducted by the author

a small staff may wish to function as a committee of the whole, that others may combine committee functions into two or three committees and that the balance may prefer to establish a large number of standing and special committees. The structure of committee organization is a decision to be made by the medical staff so long as the following required committee functions are carried out: executive committee; qualifications or credentials committee; joint conference committee; medical records committee; tissue committee. The functions of the medical staff are expressed by the joint commission in their publication, *Standards for Hospital Accreditation*, as:

- Clinical or professional care.
- Review and analysis of clinical work.
- Medico-administration management (the latter includes serving as advisor to the hospital governing board on professional matters).
- Control of clinical work.

Their execution requires that the medical staff perform the following duties:

- Selection of those recommended for staff appointments and hospital privileges.
- Constant analysis and review of the clinical work done in the hospital.
- Support of medical staff and hospital policies.
- Maintenance of adequate medical records.
- Procurement of autopsies.
- Holding of necessary consultations.

Membership on the medical staff of any hospital is a privilege and carries with it certain responsibilities. One of the most important of these is the responsibility for increasing the diligence and efficiency of the staff to assure high standards of medical care to the patient.

The most commonly accepted method for facilitating improvement in these areas is to require a thorough review and analysis of clinical work done in the hospital at periodic (at least monthly) meetings of the staff. To accomplish this it is necessary that the conduct of the staff be governed by certain rules and regulations and further, that these be reviewed in the light of the work of the staff.

The purpose of having certain committees, either standing or special is to facilitate and expedite the duties of the medical staff. It is the responsibility of these committees to determine the facts, digest them thoroughly, describe them adequately and then present them, together with their recommendations, to the staff as a whole.

SURVEYS PARALLEL

If the purposes of these committees, either standing or special, differ because of the size of the hospital, it is not apparent in recent surveys. A survey of small hospitals in Ohio produced findings closely parallel to those of Louis Block, Dr. P.H., whose prototype studies of nonprofit hospitals include those of 50 and 100 beds.

His analysis shows that the average hospital of 50 beds has a medical staff of 33 doctors, of whom 15 are active, 8 courtesy, 1 honorary, 2 associate, 6 consultant and 1 otherwise classified. Further, that in the average 100-bed institution the medical staff has 65 staff members, of whom 27 are active, 6 associate, 20 courtesy, 8 consultant, 2 honorary and 2 designated as being in some other category.

The Ohio study further paralleled that of Dr. Block with respect to committees. (Here again, because of their national scope, his statistics are used.) They indicate that in the 50-bed hospitals (100-bed figures are shown in parentheses) approximately 90 per cent (95 per cent) had a chief of staff; 60 per cent (80 per cent) an executive committee; 70 per cent (80 per cent) had standing committees; 75 per cent (98 per cent) regular staff meetings; 50 per cent (80 per cent) a medical records committee; 50 per cent (80 per cent) a credentials committee and 77 per cent (90 per cent) had written regulations governing staff conduct.

The survey showed almost unanimous objections from the small hospitals in Ohio to having the staff "as a whole" perform the

CONCLUSIONS ON THE PERFORMANCE OF STAFF WORK

- It appears that there can be little question as to the functions of the medical staff. They are well defined and apply to all hospitals regardless of size and ownership.
- These functions can be performed best in almost every hospital through committee action, regardless of the size of the institution or medical staff and irrespective of ownership.
- Hospitals should have an executive committee.
- The capacity for getting committees to actually work and get their jobs done depends on the leadership abilities of the president of the staff and in turn on the committee chairmen he appoints. Negative leadership depends largely on the instinct of fear. Positive leadership will not hesitate to suspend or dismiss a doctor if the need appears indicated but it relies on positive motives and hence leads to willing cooperation which results from the integration of the interests and desires of the doctors with the hospital's objectives.
- Leadership requires good supervision on the part of the president of the staff, recognition of authority on the part of each committee and willing cooperation of the members.
- Finally, the principles of scientific management, relating to the role of committees as developed by industry, are equally applicable in either the medical or hospital fields. There is nothing elaborate or technical about their application to professional accounting or to getting committees to get their work done in the interests of improved patient care. The scientific method as it relates to staff functions and their performance, like clinical medicine, is merely a scientific way of thinking. ■

functions of the medical staff. It was their consensus that it is almost impossible to get the entire staff to discuss initially the responsibility of one of its members, especially in instances involving possible neglect or inefficiency. To them, prior referral to a fact-finding committee is better insurance that the staff will not neglect its duty of self-discipline.

The staff "as a whole" tends also to bog down on details, since the various members have varying degrees of interests in what should be mutual problems. Such staffs find it difficult to agree that certain problems exist. The members tend to tire and become bored at defining them. Obviously it is difficult to find solutions to problems whose existence is denied.

PROPRIETARY HOSPITALS

In the 15 per cent of this nation's hospitals that are proprietary —where one might expect a preference for dispensing with committees—the reverse is apt to exist. Such staffs object to domination by dominant personalities They find there is the temptation for one or more individuals to try to work out problems or differences with each staff member individually. This allows room for personal feelings. In proprietary hospitals the staff frequently has a function not so applicable in nonprofit institutions—namely, financial accounting and financial solvency of the hospital.

It is not unusual to find one of two situations prevailing in profit hospitals. In the first, committees are nonexistent because of the dominance of one individual, who may have attained his status as a founding father or by acquiring control through his financial ability or interests. In the other, the existence of committees often stems from shared financial responsibilities. It is difficult for them to separate professional accounting from financial considerations. All doctors should realize that their stake in any institution depends to some extent upon the reputation of the medical staff and the hospital but economic factors can easily affect the degree of realization. Financial concern may decrease the interest in quality as related to adequate medical records, autopsies and review of clinical work.

The opinion expressed by numerous hospitals of all types studied was that almost every staff requires at least an executive committee. All business should be channeled through it and be accompanied by the authority to act on all important matters that may arise where it is impossible or impractical to call the entire staff together.

These conclusions were based on the size, ownership and composition of the staff rather than on the number of beds in the institution. Some hospitals reported that they set one afternoon per week aside for professional accounting. A luncheon meeting provides time for disposition of social and economic discussion and avoids digression during the formal meeting. In each instance the medical records committee, often as a one-man assignment, has perused the records in advance and reports inadequacies and discrepancies.

According to the study, it appears practical for small staffs (of more than eight active members), irrespective of the size of the hospital, to appoint as a minimum an executive committee and to consider at least a one-man medical records committee. There will be exceptions to this, for example in proprietary hospitals where ownership is vested in one or two men and the staff is small, but the principle remains sound and should serve as a "rule-of-thumb" guide in evaluating existing staff structure.

PROFESSIONAL ACCOUNTING

The majority of hospitals surveyed indicated they had no solutions to the problem of how to get the work of committees done. They were agreed that this is perhaps the greatest problem a medical staff faces in professional accounting. There was no disagreement that organization of some type is required if the best interests of the patient are of concern. Further, that one necessary action in any hospital regardless of size is to hold a final burial service for professional jealousy. Professional accounting requires sincerity, complete honesty and the avoidance of the construction of a medical shrine at which its members can worship.

From observations and experience the key to success in committee work may lie in two preliminary steps: (1) the election of a president of the medical staff and (2) the manner of appointment of committees.

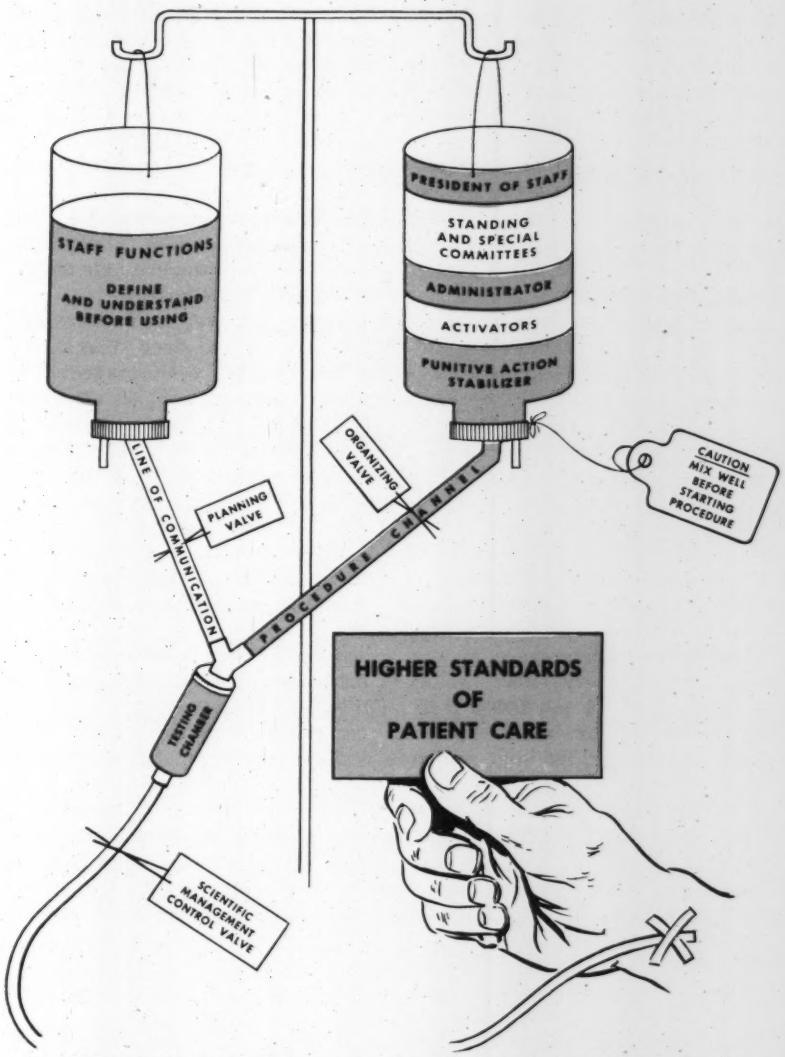
The selection of a president should be based on his administrative and organizational abilities rather than on his professional qualities or popularity. In smaller hospitals, the position of president of the staff and chief of staff are usually filled by the same individual. His authority and responsibility must not conflict with those given the administrator. Further, his primary loyalty is to the administration of the hospital rather than to the interests of the medical profession whom he represents as their president.

DELICATE POSITION

This two-fold position is at best a delicate one. The person elected must have the respect for and a desire to achieve higher standards of patient care. He must be capable of arousing interest and enthusiasm in the staff. The individual should be eligible for reappointment but should initially win and then retain his position because of respect. His approach to the appointment of committees must stem from a deep-seated belief that they should be educational, not punitive. The appointments themselves, where possible, should include men of similar ideals and principles.

Committee chairmen should be men with an honest acceptance of duty, who have demonstrated loyalty to the aims of the staff and hospital and whose self-respect does not recognize professional jealousy. Membership should include, for purposes of education, those who are critical of the need for self-discipline, self-education and self-appraisal. The right to criticize is the offspring of two characteristics—sincerity and participation. A staff member's own colleagues are best qualified to conduct the orientation and education of the "difficult" individual. When possible, men should be assigned to committees whose work is in keeping with their interest and abilities.

Proper and careful selection of



How an actively functioning medical staff contributes to higher standards of patient care.

the president of the staff and in turn his considered opinions in making appointments are not sufficient if committees are to actually get their work done. The next step is the application of scientific management principles to the solution of problems of staff administration. This requires substituting rational analysis for trial and error.

The first stage is recognition of the problems. Here the standards of the joint commission can serve as a pattern since they define the minimum objectives toward which a staff should work and the requirements for their proper attainment. The commission will furnish on request additional information regarding the factors that enter into the problem and the principles governing their control.

Having defined the objectives, the next step is to examine the existing organization to see to what extent the goals are now being met. Then comes the determination of the requirements for a proper application of the solutions and the results which may be reasonably expected. (At this point, if accreditation is one of the goals, it may be necessary, as a last resort, to bring in outside professional assistance to do a medical audit.)

By way of procedure, the president should hold at least one meeting of all committee chairmen for the purpose of defining the problems and to establish lines of authority, procedure and methods of evaluation. This should be followed by a similar meeting of the entire staff for purposes of their orientation and education.

This latter must be carefully planned since staff members may lack familiarity with the new requirements and not possess a thorough and complete understanding of the significance of the goals. Mental inertia and the tendency to revert to previous work and thought patterns may have to be overcome. Therefore, rules must be set, regulations determined, a review provided for and responsibility delineated. The time when committee meetings are to be held should be definitely established and should leave no excuse for neglect of duty. There should be no question that staff rules will be rigidly enforced regardless of the hardship on any individual doctor. It must be pointed out that accepting responsibility is not self-sacrifice, rather it is an obligation far offset by the rewards of privileges.

The president of the staff should meet with his committees whenever possible and initially he must of necessity. It is up to him to sell the proposition of committee work to his staff, to outline the proposition, ask for suggestions, assign problems and follow up on their actions.

ADMINISTRATOR INVITED

A good procedure is to invite the hospital administrator to all staff meetings and to all committee meetings where his assistance could be helpful. The survey indicated that many of the administrators had never been invited to attend committee meetings, or even staff meetings. The majority of them do attend all staff meetings and many of the important committee meetings—usually without any question being raised as to their presence.

A solution used by many staffs is to include in their bylaws a provision for making the administrator an ex officio member of the staff and all its committees. This is logical since his assistance should be sought and forthcoming to find solutions to reduce the administrative load on the doctors and to provide the facilities and assistance (often clerical) to enable them to carry out their duties.

In too many institutions, the staff is hamstrung by antiquated, ill-advised or poorly designed administrative procedures. It is the administrator's responsibility to remove administrative detail from

their shoulders and to conserve their time for the careful evaluation of quality and professional accounting. In so doing both parties must accept their respective responsibilities and avoid stooping to blame the other. They must be mutually dedicated to keeping the patient in focus as the most important part of the picture.

One procedure which helps establish and maintain this relationship is the creation of a formal means of liaison such as a joint conference committee composed of the executive committees of both the board and staff with the administrator in attendance. If the positions of chief of staff and president of the staff are vested in the same individual, he should be invited to attend all meetings of the hospital's governing board, to submit his reports in person and to actually serve as its medical advisor. He should be accompanied, when indicated, by members of his staff who can serve as additional advisors.

Extending representation on the hospital governing board to a limited number of selected doctors is now considered by some hospitals to be an excellent mechanism for establishing mutual understanding and confidence. They feel it gives an added sense of direction to the work of the committees of the staff and encourages them to get their work accomplished.

CLEARING HOUSE

If committees are to really function, it should be understood that they serve as a clearing house for complaints and problems that do not justify the time of the entire staff. The committee's agenda should be established in writing and in each member's possession well in advance of meeting dates. Some doctors will do some thinking about the problems before coming to the meeting. Minutes of each meeting should be carefully and completely recorded and should be furnished all members of the staff as soon as possible. This is the best way of keeping them informed of committee work and it allows them time to present suggestions or criticisms to the committee in advance of the regular staff meeting at which the committee's recommendations are to be reported. Actually the study of such matters should not be foreign to their daily thought and reserved only for the days of meetings. The conscientious committee member will not shirk his duty nor overlook the significance of his obligations. He will constantly be aware of his responsibilities and relate them to the daily experiences of his practice.

Committee meetings should be properly conducted or attendance will be poor. They should be held in comfortable surroundings and the meeting room should be well equipped for the committee's needs. Its furnishings may well include a wire or tape recorder, blackboard and such visual aids as are needed to present hospital statistics, graphs, financial reports such as per diem costs, hospital occupancy charts, etc. The date and time for meetings should be established at the convenience of the members and every effort should be made to start and adjourn at the appointed times. Discussion should be limited to that which is pertinent. Procedure may include the establishment of time limits for debate of controversial matters. Wherever possible, the committee should use established and recognized aids in gathering and presenting their material for discussion. This is especially important in the tabulation and control of tissue reports and the evaluation of medical records by means of a formulary.

MECHANICS FOR DISCIPLINE

Persuasion is of course preferable to discipline. The mechanics for the latter, however, should be well established and employed without question if the need arises. Since the ultimate purpose of any committee should be to get the work done in a manner that will insure better medical care of the patient, their performance can never be any better than the adherence of the staff to well established, definitive and complete bylaws governing its behavior.

It is difficult to get the staff as a whole to discuss initially the exact responsibility of an individual member when his behavior is questioned or in instances of possible neglect or inefficiency. Referral to a committee for prior study is immeasurably more successful. Knowledge that his actions are subject to committee review will frequently cause a physician to exercise his best care and judgment, since failure to do so would result in injury to his professional reputation and career. The threat of suspension or permanent loss of privileges should always be thinly veiled as the ultimate means of control if necessary.

Even positive leadership requires controls since they: (1) insure proper performance; (2) secure coordination of effort in conformity with the requirements of performance and; (3) remove interferences with the proper execution of any plan for improvement of patient care.

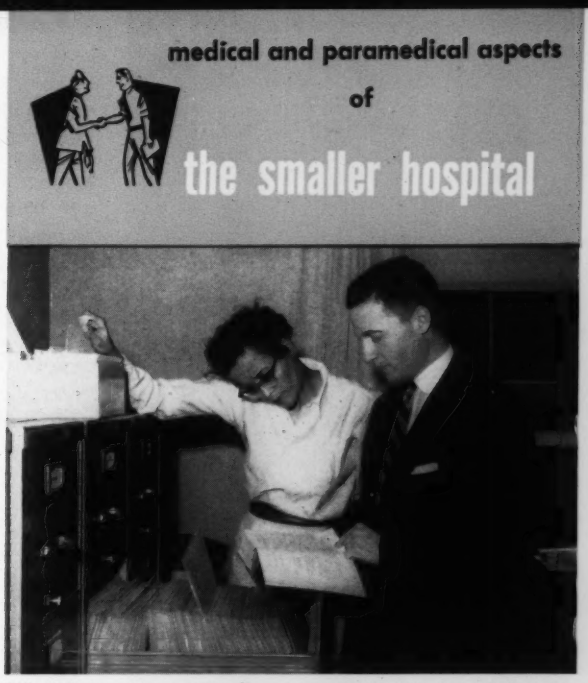
There are still a few principles of scientific management which affect the work of committees that need to be woven into the procedures already indicated. Various practical considerations will arise during the tenure of office of any committee which were not previously apparent and which may affect their ability to get the work done. For example, the medical record librarian or administrator may leave or the leadership of the staff may change. Discouraging, yes, but it should be at best only a temporary deterrent, for it is well established that the scientific solution to any problem is always a spiral process.

There should be periodic reviews of the constitution, bylaws, procedures and committee composition. Necessary revisions must be made to keep pace with the evolution of medical care and the changing needs of hospital operation. New staff members should be immediately assigned to working committees for the purposes of association, orientation, stimulation and education. Committee chairmanships and memberships should be rotated periodically for the same fundamental reasons. A nucleus of old members should be retained to accelerate and perpetuate their work.

The appointment of a vice chairman, eligible for elevation to the position of chairman, is a technique frequently employed.

One of the reportedly most successful "working" staff organiza-

(Continued on page 111)



THE MEDICAL records librarian of Community Hospital of Evanston discusses coding and indexing procedures and the use of standard nomenclature with the hospital administrator. Record keeping often poses problems for smaller hospitals working for accreditation.

hidden assets of accreditation

by HOWARD F. COOK

Replies received by the author in a survey of 60 smaller hospitals indicate that in general, administrators of smaller hospitals believe that the Joint Commission on Accreditation of Hospitals is performing a worthwhile service and doing it well. A JCAH "seal of approval" was considered a valuable asset in many areas, including malpractice insurance rates, personnel recruitment, community relations, and work standards of hospital personnel.

TO ACHIEVE an accredited status requires work, worry and money for any hospital—whether large or small. It is, however, generally agreed that accreditation is somewhat easier to achieve in a large hospital located in a metropolitan area than in a small hospital with limited financial and personnel resources.

Do administrators of small hospitals feel that the work, worry and money required to achieve the "seal of approval" of the Joint Commission on Accreditation of Hospitals are justified? Are there ancillary advantages in an accredited status beyond accreditation itself?

To gain some indication of how administrators in small hospitals across the country feel about these questions, 60 administrators in 16 states were sent a brief questionnaire.

The consensus of replies is best summed up in the statement made by an experienced administrator of a 60-bed general hospital in Massachusetts, who wrote, "People who work or are sick in a small hospital want to feel it is essentially as good as the larger ones," with which the author agrees wholeheartedly.

Hospital accreditation was initiated, almost by accident, 40 years ago by the American College of Surgeons as a means of carrying forward the college's requirements for fellowship. The ACS required, among other things, that in order to qualify for fellowship the surgeon must present 50 complete medical records of patients upon whom he had performed major surgery. The thought behind this requirement was that clinical training certificates and educational diplomas were by themselves meaningless if the surgeon was unable, in actual day-to-day practice, to obtain good surgical results.

However, the college soon found that far too many surgeons were unable to produce medical records of the caliber required. It was suggested that one cause of the difficulty lay in the quality of hospital facilities.

For these reasons, the regents decided to survey 100 hospitals. When they met at the old Waldorf Astoria Hotel in New York to review the reports of the survey they found:

- The average hospital lacked laboratory, x-ray and other essential diagnostic and therapeutic facilities for preoperative study;
- Medical staffs were not organized for proper supervision and control of professional activities;
- Many services were inadequate or totally lacking;
- There were few, if any, medical records worthy of the name being kept in the average hospital.

So horrified were the regents at the results of their survey that they marched down to the Waldorf boil-

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THE preanesthetic examination and postanesthetic follow-up requirements for accreditation call for cooperation between the anesthetist and the medical staff. Here, the hospital's nurse anesthetist confers with a doctor and a nurse on the handling of anesthesia equipment and records.

THE house physician, attending physician and medical technologist of Community Hospital of Evanston discuss the laboratory test reports that must be filed with a patient's record as a requirement for accreditation.

er room and watched while the engineer destroyed the detailed survey results.

The ACS then set about preparing a set of standards for hospital operation to which all hospitals could aspire. Under the leadership of Franklin H. Martin, M.D., secretary general, and John G. Bowman, M.D., director, minimum standards were prepared.

In 1923 Malcolm T. MacEachern, M.D., joined the staff of the ACS. To many administrators today, Dr. MacEachern and "hospital standards" are still synonymous. His impact upon the growth and acceptance of this wholly voluntary program will not soon be forgotten by the hospital field.

Of the 692 hospitals surveyed by the ACS during the first year of the program, less than 13 per cent passed the test. By 1950, however, there were 2,429 hospitals under survey—of which almost 95 per cent received approval.

At this juncture the ACS reviewed its total program for its membership and found that $2 million had been spent on hospital standardization. ACS decided that it would be desirable if the program were continued as a joint responsibility of hospitals and medicine.

As a result, the Joint Commission on Accreditation of Hospitals was established in 1952 through the combined efforts of the American Hospital Association, American Medical Association, American College of Surgeons, American College of Physicians, and the Canadian Medical Association. Its sole purpose is "to improve the quality of patient care in hospitals."

THE SAMPLE

The size of the sample polled in the survey mentioned earlier precludes any final judgments being made from the results. Nevertheless, the author considers the replies of sufficient merit to report and at least indicative of small hospital opinion nationally.

The 45 replying hospitals are located in all regions of the United States. All types of control are represented: city, county, nonprofit, church-connected and Sister-operated. From the standpoint of service, special as well as general hospitals are included. Both accredited and nonaccredited hospitals received questionnaires.

PERSONNEL RECRUITMENT

The questionnaire asked if, in the opinion of the administrator, accredited status was helpful in recruiting registered nurses, practical nurses, medical technologists, x-ray technicians, dietitians, or medical record librarians. Seventy-three per cent of the administrators felt that accreditation helps to some degree in personnel recruitment. Most felt that it helps a little. Eleven administrators (about 25 per cent of the sample) felt it helps "a great deal." Twenty-six hospital administrators stated accreditation seems to be of particular help in obtaining registered medical record librarians. Next highest on the list were laboratory technicians. Accreditation seems to be a less influential factor in determining the place of employment of practical nurses than any of the six vocations listed.

The author believes the fact that registered nurses, medical technologists and other paramedical personnel seem to be taking into account hospitals' accreditation status is extremely important. This interest is doubtless a result of the publicity given this program by the Joint Commission on Accreditation of Hospitals and its constituent organizations. The current shortages of qualified paramedical personnel and the concomitant emphasis these groups are placing on accreditation would seem to make it more important than ever for the small hospital administrator to seek accreditation. It is well recognized that small hospitals have a more difficult time attracting qualified personnel than do their larger, wealthier colleagues. If accreditation can help—and apparently it can—it would seem eminently desirable for the small hospital, lacking a national or regional reputation, to display the joint commission's "seal of approval" in its lobby.

MALPRACTICE INSURANCE

Forty-one of the 45 hospitals replying stated that they carried malpractice (liability) insurance. To determine the influence of accreditation on this aspect of hos-

pital operation, we asked several large writers of malpractice insurance "if accreditation has any effect upon the rates charged—and the extent to which accreditation or nonaccreditation might affect the cost of the insurance and its availability to a hospital."

The replies are worth quoting. One stated, "It is our understanding that [accreditation] is taken into consideration as a factor determining the premium to be charged for a specific risk. In some cases the failure of the hospital to be accredited may, with other factors, result in a refusal to write the risk."

Another replied, "The question relating to accreditation in our proposal form is used as a convenient means for risk selectivity. As a general underwriting practice we limit our acceptances of Hospital Professional Liability risks to accredited organizations and seldom, if ever, are persuaded to undertake a hospital which is not accredited."

A third underwriter wrote, "We provide coverage only for accredited institutions and it plays a very important part in our underwriting procedures. Our engineers are fully familiar with the requirements as established by the accreditation body."

Few hospital administrators and even fewer medical staff members and members of boards of trustees realize the emphasis placed on accreditation by insurance companies. It is a matter worth thinking about.

ADMINISTRATOR'S VIEWPOINT

The questionnaire asked if accreditation was a factor influencing administrators in accepting an administrative position. Only two administrators stated they would pay no heed to the hospital's accreditation status. Twenty-two administrators (almost half) said they would decline any administrative job in a hospital eligible for accreditation but which had not qualified. A number of others stated they would accept jobs in nonaccredited hospitals as a challenge if they felt the hospital's board would support the goal of accreditation.

Another question asked if the administrator felt that well informed persons and leaders in his community had a general understanding or appreciation of the meaning of hospital accreditation.

The fact that half of the replies were affirmative is encouraging. On the other hand, if we are to assume that the other half lacks this appreciation, it is obvious that an important job of public relations by the joint commission and its constituent groups is in order.

One administrator trenchantly replied: "To the general public in this small community, accreditation means nothing. They don't even know the meaning of the term. That is perfectly satisfactory with me. I feel that the standards of this hospital are my job—not theirs."

The hospital administered by this individual is accredited. Nevertheless, the writer believes the viewpoint expressed is shortsighted, for it is a basic precept of good administration that the community is entitled to an independent evaluation of its hospital facilities and that an administrator is accountable to the community as well as to himself.

SMALL HOSPITAL OPINION

As the final question in the survey we asked, "Please give your candid impressions of the major strengths or weaknesses of the accreditation program insofar as small hospitals are concerned."

The "essay" type of answers given defy statistical interpretation. But it is significant that not one administrator failed to answer this question. Some wrote answers three and four pages long.

In general, the respondent hospitals are solidly behind the accreditation program. Many expressed the belief that the single most valuable aspect of hospital accreditation is the establishment of standards by the commissioners. Several went so far as to state that the establishment of standards outweighs the value of the actual survey.

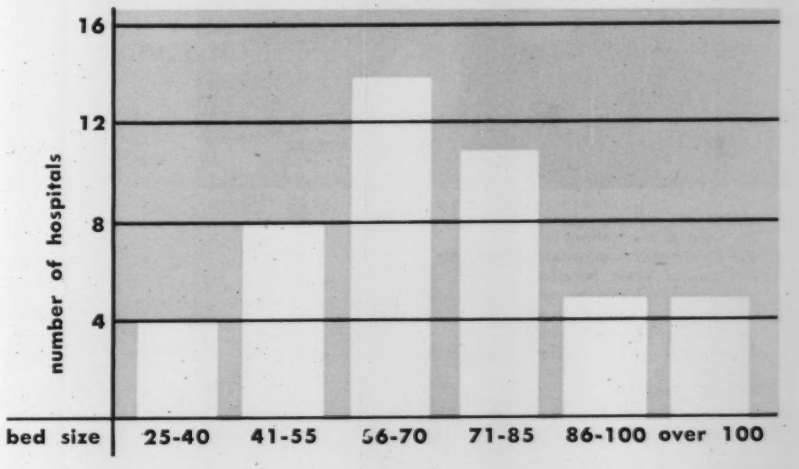
A number stated that the surveyor's visits and the joint commission's written recommendations constituted a most helpful tool in dealing with the medical staff, hospital employees and their boards of trustees. These administrators felt that without the survey they would be unable, or at least less able, to improve services and standards. They said the surveyors help keep them "on their toes," that the survey provides "an impartial medical audit by an individual conversant with the best and latest thinking on hospital practices."

On the other hand, a disturbingly large number of administrators expressed the belief that neither the joint commission nor the surveyors take sufficient account of the fact that small hospitals lack interns, residents, and medical clerks to provide the type of medical record easily attainable in large hospitals but "almost impossible to attain in small institutions."

Another factor mentioned by about 25 per cent of the administrators is best summed up by the comment of one who wrote, "I get

(Continued on page 114)

bed size distribution of hospitals returning questionnaires



bringing radioisotopes to small communities

—the Kansas program

by FRANK E. HOECKER, PH.D. and HOMER L. HIEBERT, M.D.

TEN YEARS AGO the term *nuclear medicine* would have meant little more than an incongruous combination of words. Today, it represents an accepted branch of medical practice and a service which is available to increasing numbers of patients in many small hospitals.

Even as short a time as six years ago clinical uses of radioactive substances for either diagnosis or treatment of disease were restricted to a few large hospitals or medical schools able to support research

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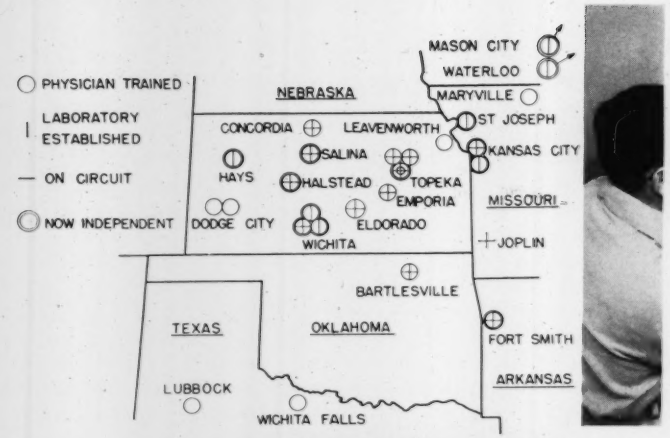


THIS is a corner of the radioactive isotopes laboratory in Hadley Hospital, Hays, Kansas. It was the first such small hospital laboratory established in Kansas and it has been in operation since 1952. The equipment shown is being used to survey the thyroid area of a patient to determine the up-take and distribution of absorbed iodine.

The program for bringing radioisotope service to smaller hospitals described in this article has made the advantages of radioisotope diagnosis and treatment available to residents of many of the smallest communities of Kansas. It will be many years before enough radioisotope technicians are trained and perhaps before they are needed on a full-time basis, the author observes, but even small hospitals can independently provide the service by seeing that their x-ray technicians or medical technicians have the necessary instruction.

ABOVE: the training laboratory used in the Kansas radioactive isotopes program. This typical small hospital laboratory illustrates the recommended equipment and convenient arrangement. RIGHT: the original pilot laboratory in Stormont-Vail Hospital, Topeka.

HOSPITALS in other states have established radioactive isotopes laboratories with the help of the Kansas program. This one was established recently in the Frank Phillips Memorial Hospital, Bartlesville, Oklahoma.

programs in the field of medicine. A few specially selected cases of hyperthyroidism or polycythemia were treated with radioactive isotopes with a "last hope" attitude when other means had failed.

Radioiodine was just on the verge of acceptance as a diagnostic procedure in medical centers with well equipped research laboratories where a radiological physicist was available to perform the tricky standardization procedure. Under such conditions the advantages of radioisotope diagnosis and treatment were available to a very small fraction of the total population.

In spite of the great promise that radioisotopes offered both diagnostically and therapeutically, certain very important factors prevented their widespread introduction into small hospitals:

- Lack of physicians who had experience or training in clinical radioisotope applications.
- Lack of standardized radiopharmaceuticals with the consequent necessity for standardization of the administered dose by a radiation biophysicist.
- The familiar high cost of laboratory equipment and uncertainty on the part of physicians regarding what equipment to purchase even when the necessary funds were available.

These problems were closely interrelated and stemmed directly from the extremely rapid development of the entire field of nuclear energy under the impetus of military exigency. The termination of the military emergency left vast facilities for producing radioactive substances but no parallel program for training in radioisotope applications.

Medical curricula are notably slow to respond to scientific developments and had been further restrained by military demands. The critical shortage of physicians left little opportunity for those in civilian practice to spare the time for training in new developments.

These shortages were matched by a similar shortage of medical physicists, though this was not due to the same underlying causes. In 1949 there were only about 50 physicists in the United States certified by the American Board of Radiology. Still fewer of these were certified in the field of nuclear medicine. This shortage was due in large measure to lack of interest in medical problems on the part of physicists, a condition which is being slowly alleviated by the development of university training programs in radiation biophysics and radiological physics.

EQUIPMENT IS PROBLEM

The equipment problem was closely related to that of trained personnel. In addition to the need for specialized radiation counting equipment required for diagnostic measurements, the assay of radioisotope doses required additional equipment and the type of training in radiation physics rarely possessed by a physician.

The responsibility associated with administration of therapeutic doses assayed by doubtful procedures and questionable equipment exerted an inhibiting influence on physicians in most small hospitals. Trained and experienced radioisotope technicians had hardly been thought of and it was necessary for the physician in the small hospital to contemplate the prospect of adding to his own already burdensome load if he were to undertake clinical uses of radioisotopes.

Such was the status of clinical applications of radioisotopes in 1950.

At this time a fortunate conjunction of favorable forces occurred in at least one region. The University of Kansas had recently embarked on a program in radiation biophysics aimed at training students in the borderline area between biology and physics with emphasis on the field of interaction between radiation and biological organisms. Preeminent in the field are the medical applications of radiation and radioactive substances.

The University, through this radiation biophysics program, undertook certain steps designed to provide training for physicians, biophysicists, radiological physicists and radioisotope technicians.

At the same time a group of physicians in Topeka undertook to pioneer the spread of radioisotopes into small hospitals. Following a special course in the clinical applications of radioisotopes sponsored by the Medical Extension Division of the University of Kansas in which 27 physicians of the area enrolled, the first small-hospital laboratory was set up in Stormont-Vail Hospital, Topeka. Shortly thereafter, a grant from the Kansas Division of the American Cancer Society provided funds which permitted the design and testing of methods and equipment with regard to its suitability for small hospital use.

DIFFERENT CIRCUMSTANCES

Although the clinical objectives of radioisotope usage in small hospitals are the same as those in large hospitals, the circumstances are usually different:

1. Small hospitals usually have limited financial resources for elaborate equipment.
2. Most of them lack specially trained physicians.
3. They generally lack full-time or part-time radiological physicists.
4. Small hospitals have limited laboratory space.

Radioisotope procedures and equipment must fit these limitations; the essential procedures should be as simple as possible

and require a minimum of time; the equipment must likewise be as simple as possible and must be dependable—requiring a minimum of servicing and adjustment.

The pilot laboratory studied these requirements, at the same time performing under actual operating conditions of a clinical program. Methods and equipment were revised and adapted to fulfill the special needs.*

Simultaneously this laboratory served as a training center for physicians who were alert to the promise of nuclear medicine. Initially, the training was confined to applications of radioiodine in diagnosis and treatment of thyroid disease. One of the features of this pilot program was the concentration of patients to provide radioisotope sessions of two days duration in which 10 to 12 patients were studied.

THOROUGH DIAGNOSTIC STUDY

Another unique feature was the thoroughness of the diagnostic study. The objective was to study all pertinent aspects of iodine metabolism: the per cent uptake, the uptake rate, the detailed excretion curve, the conversion ratio and the surface scan of the thyroid area, all in relation to other diagnostic evidence and the case history.

Working with the physician in charge through several of these two-day sessions, the trainees were able to study patients having a wide variety of thyroid disorders and at the same time receive instruction in instrumentation techniques and safe handling procedures by working with the radiological physicist. In this way many physicians received the training and experience required by the United States Atomic Energy Commission and were approved for the use of radioiodine in their hospital isotope laboratories.

Even streamlined methods and simplified equipment do not eliminate the time required for a thorough diagnostic study, however. The demand for trained radioisotope technicians was intensified and it was apparent that the output from the training program at the University of Kansas could not meet the demand for several years to come. In this emergency, the radioisotope research program in radiation biophysics, which had been underway at the University since 1947, was able to fill the void.

CIRCUIT ESTABLISHED

One of the research assistants with several years experience was given additional training in clinical procedures in the pilot laboratory in Topeka. His services were then made available to hospitals and physicians in Kansas, Missouri, Arkansas and Oklahoma. A hospital circuit was then established in which the radioisotope technician visited each hospital on a monthly schedule which permitted the physician to make appointments with patients for a two-day or a four-day session. For the physician in charge, the radioisotope technician rendered all desired services involved in handling procedures, physical measurements and preparation of data reports. The physician, relieved of the technical details, was free to interview and examine the patient, to interpret the tracer study results, and to make the diagnosis.

There is no categorical answer to the question of how successful a clinical radioisotope program is in a small hospital. As with every other clinical service, its success depends upon the ability and interest of the physician in charge. To a marked extent it depends upon his community relationships and the interest of other physicians with whom he works.

The best answer to the question is demonstrated in the map on page 40, which shows the small-hospital isotope program developed during the past six-year period. The symbols indicate physicians trained and hospital isotope laboratories established. All of these programs have experienced a gradual growth and have in general reached an equilibrium conditioned by the area they serve and the other factors mentioned.

TECHNICIANS TRAINED

This hospital radioisotope circuit program is now in its fifth year, during which several radiation biophysicists have been trained at the University of Kansas and have taken full-time positions at hospitals whose isotope services have expanded beyond the circuit state. Special courses have been given recently at the University in radioisotope techniques to familiarize physicians with the biophysical bases for the broad spectrum of clinical application for many different radioisotopes.

Plans for a similar course specially tailored to the needs of x-ray technicians or medical technicians who may wish to add the new techniques to their repertoires are being developed. These technicians already possess many of the basic techniques which are applicable to the clinical uses of radioisotopes and need only to supplement them with an understanding of the principles of radioactivity and high energy radiation to become valuable assistants to physicians who are developing radioisotope programs.

Several factors have opened the field to these technicians. The development of standardized radiopharmaceuticals has eliminated the need for high precision radioassay of administered doses. Equipment also has become more standardized and dependable and electronics service more readily available. Even the physical measurement procedures appear to be well on the way to standardization as a result of intensive studies carried on at the Oak Ridge Institute of Nuclear Studies.

The Kansas clinical radioisotope program through the small-hospital circuit and physician training has rendered a service to the people in its area by making the advantages of radioisotope diagnosis and treatment available to those who live in even the smallest communities.

These were unquestionably temporary services rendered during a transition period which will soon be supplanted when medical students who are now receiving formal training in radioisotope applications take their places in communities. It will be many years before enough radioisotope technicians are trained and perhaps before they are needed on a full-time basis, but even small hospitals can independently provide the service by seeing that their x-ray technicians or medical technicians have the necessary instruction. ■

*See: Hoecker, F. E., Ph. D., and Hiebert, H. L., M.D. Pocket-sized isotopes program. HOSPITALS, J.A.H.A., 28:84 Oct. 1954.

the board and the administrator:
spelling out their relationship

by ROBERT E. GRIFFITHS

As the author discusses the intricacies of the board-administrator relationship, he considers the context of the hospital organization as it affects this relationship, the areas of authority of both administrator and board and the various means of contact between the administrator and the board.

THE ADMINISTRATOR'S association with the governing body of the hospital is perhaps the most challenging aspect of his professional activities. Whether a hospital is small, medium or large, its achievements are most enduring and its objectives most effectively realized through the common endeavor and mutual respect resulting from this association.

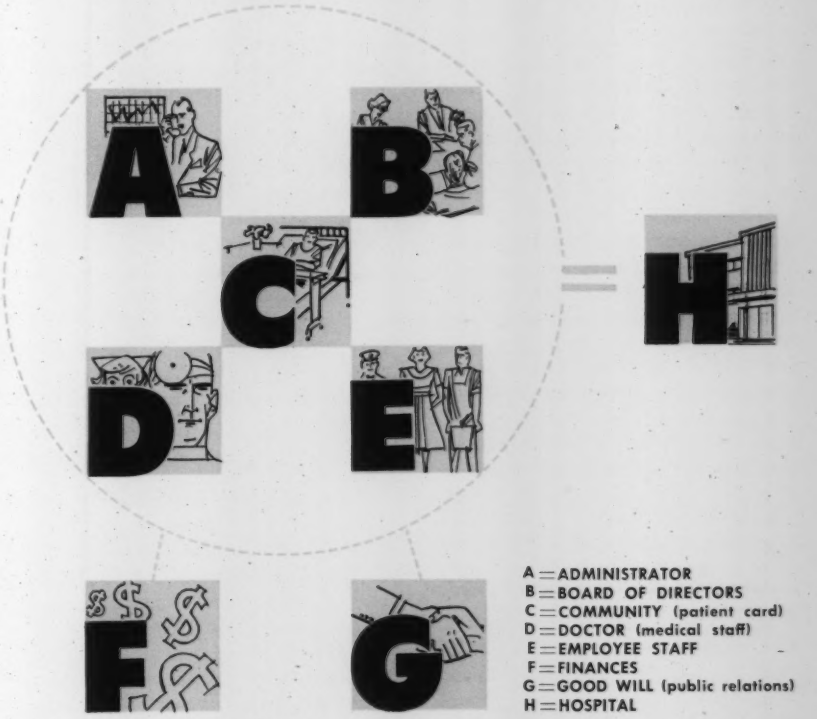
Board-administrator relationships are considered best in the context of the entire hospital organization. The accompanying drawing symbolizes the major elements of a hospital. Oversimplified, the A-B-C-D-E elements, supported by finances and good will, comprise the hospital. The five parts within the circle are related in a common purpose, each being conditioned and characterized by its association with the others. None performs solo or in a vacuum, but in consideration of all others —although admittedly too often it would seem otherwise.

A discussion of the relationship of any two elements of a hospital must be carried on in the light of the other groups. With this setting, we can more properly appreciate the intricacies of the board-administrator association and its effect upon the hospital it directs.

It might be expected that the size of the hospital would have a bearing on the essential characteristics of the relationship. This supposition, it seems to me, is unsupportable. The board's function consists of high level control and establishment of policy. These functions do not vary in kind but are reasonably constant regardless of the size of the hospital concerned.

A proper balance must exist among the elements composing the hospital. Each party should understand its own position, function and responsibility—and how its role relates to all others. Each component part must also apprehend the role of the other elements; an insight by the administrator into the crucial responsibilities of the board, and its converse.

The administrator and the board should function as a working partnership of policy and execution in the direction of hospital affairs. This can be true even though the ultimate authority is the board, for



Robert E. Griffiths is administrator, Appleton (Wis.) Memorial Hospital.

the executive head is deeply involved in policy matters through his obligation to recommend action to the board, to advise on policy formation, and to execute policy decision. Hospitals that have made the administrator a member of the board have recognized this fact.

AUTHORITY OF BOARD

The board of directors is sovereign—that is, it possesses independent authority. The hospital corporation's charter provides for a governing body and endows it with authority—the authority to provide physical facilities, personnel (both lay and medical), and to carry out the functions of the hospital as stated in the charter.

Although the board is representative of the community, it holds its authority from the state which grants the charter. Each board member should clearly understand that he cannot surrender this power to anyone. The final responsibility is the board's. It behooves the administrator to bear this in mind as he functions in the capacity of the board's agent.

The authority of the board is stated in broad terms in the articles of incorporation. To give effect to this power, policies are established, and an organization is created. The act of policy making is not a static thing, unalterable or unchanging. Rather it is a continuous responsibility demanding change in keeping with community needs and structure, and involving medical, social and economic considerations.

To the administrator, then, goes the authority to carry out the board's policies as they are entrusted to him. Knowing its limitations, the board relies upon its appointee to organize the over-all hospital operation and to achieve the predetermined goals. The governing body, however, must assure itself that its directives are being executed according to general policies. In this sense the board has a top-level "supervisory" function. In such a context the board-administrator relationship is established and maintained.

MANY-SIDED RELATIONSHIP

Positive results of this association stem partially from the intelligent understanding of its various facets, both formal and informal. This relationship is at the same time many things: As its foundation, it is an association of people organized to accomplish a joint purpose through mutual confidence and interdependence. It is also an employer-employee situation. Finally, it is a "leader-led" relationship with the roles reversed at times. This latter can be a delicate state of affairs when attempting an educational program, and it is particularly apparent in the creation of a new institution.

The administrator-board relationship is not one of clear-cut demarcation with a rigid line separating one from the other in all areas of functioning. There should be an integration of effort rather than a clear-cut separation of function in those areas where board and administrator meet.

There are aspects of this association which challenge the administrator's ability to establish a partnership of hospital direction. For example, how do the professional administrator and the volunteer, community-minded citizen achieve a successful working relationship? Why has a person sought or accepted the responsibilities of trusteeship? What is the motivation? What are the satisfactions derived?

The administrator should be interested in the board member as a person, and not be preoccupied with hospital matters on all occasions. Generally, the trustee has much to offer in addition to his official status of board member.

The administrator should also know something of the board member's business or occupation. Is he or she successful? Does he have community respect? In other words, with whom is he working, and what can be expected of him? He might on occasion remind him that his trusteeship is one of the most important extra-curricular activities in which he can be engaged.

RELATIONSHIP IN ACTION

The most evident instance of the administrator-board relationship in action is the monthly meeting. It is the occasion for consideration and decision from which all action flows. Board committees also involve both board members and the administrator. These committees, whether standing or temporary, have a function which eventually must terminate in board action. The administrator is present to advise or recommend. These two situations involve the administrator with board members in formal situations. But informal contacts can be as important, and on some occasions more so.

From the standpoint of over-all hospital operations, considering both policy and execution, a third important contact is that of the board chairman and the administrator. The complexity of management today demands that this relationship be firmly established, for in these two positions is centered the administrative leadership of the hospital ranging over the entire organization.

Other contacts are between the administrator and the individual board members in their separate capacities as trustees or as citizens of the community which each represents.

The above, then, are the areas of administrator-board association so important to operational success. It behooves the participants to appreciate their separate and combined influences upon the hospital.

The administrator has the obligation to recommend programs and policies to the board. Recommendation is more than a suggestion for action. It should be supported with sound reasoning, and "put over" with the arts of salesmanship. Before it is brought to the board that body should have background information and a knowledge of the pertinent preceding events—in fact, the complete essentials of decision making. The administrator must keep the board informed. This is akin to his responsibility to assist in the continuing education of board members in the changing structure of the organization, as well as its fundamental principles.

Considered information is the basis for wise policy decision and for effective relations between the board and the community. An informed group of trustees is the vital communications link between the public and the hospital. It is the prudent administrator who provides his superiors with a running account of the state of the hospital; including, naturally, evaluation reports on the success of a

(Continued on page 111)

medical and paramedical aspects of the smaller hospital

versatility is the rule

IN GENERAL, qualifications for service in smaller hospitals are no different from those required in a larger institution. An administrator has the same responsibilities and problems as his counterpart in the larger hospital. The medical and paramedical staffs must be just as highly skilled in order to provide the same protections and services available in the larger hospital.

There is perhaps one qualification, however, that is particularly valuable —and usable—in the smaller hospital: versatility. Even though the smaller hospital is called upon to provide the same basic services as the larger one, the demand for these services may not be great enough to justify a full-time staff member for each. To meet this situation, full-time staff members are sometimes specialists in more than one field, and part-time staff members may perform their duties at two or more hospitals. The x-ray technician may also have charge of the laboratory, the director of nursing may dispense drugs and be her own personnel manager, the administrator may be his own purchasing agent and stores keeper. The radiologist may spend his mornings at one institution, his afternoons at another.

THIS PATTERN of multiple duties among the medical, paramedical, and administrative staffs is well established at Lake Forest (Ill.) Hospital, a 65-bed institution located in a North Shore suburb of Chicago.

Her training as a nurse and her experience in nursing administration have stood Superintendent Liala I. Johanson, R.N., in good stead ever since her arrival at Lake Forest Hospital more than 11 years ago. As a nurse she has taken an active part in nursing problems—even "filling in" in the operating room in emergencies. Her double viewpoint has made her doubly aware of administrative problems that are closely related to good patient care, and has helped her to maintain close relationships with doctors, staff nurses, and patients.

In other phases of hospital administration she has been equally versatile. She does her own purchasing and supervises the dispensing of supplies; she is public relations manager and methods specialist; she has daily conferences with the director of nursing, the dietitian and the executive housekeeper; lately she has been intimately involved with an expansion plan that will bring the hospital's capacity to 100 beds.

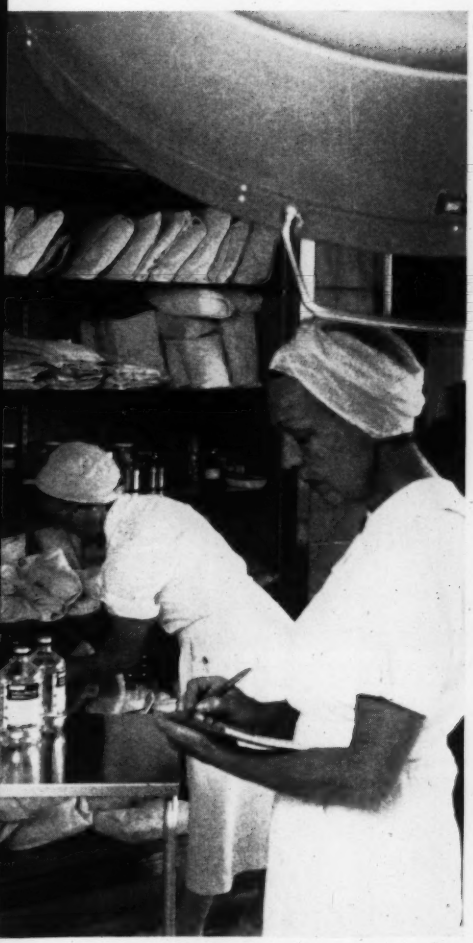
THIS SAME versatility can be seen in varying degrees throughout the hospital. The director of nursing has charge of the drug room (compounding is done by local retail pharmacists); the assistant director of nursing carries out the training of nursing aides; the medical records librarian has charge of personnel records; the operating room supervisor also manages central service.

The photographs on the following pages illustrate the close working relationships that exist between the administrative and the medical and paramedical staffs of a smaller hospital, and perhaps give some indication of the diversity of duties and the informality that make service in a smaller hospital interesting and rewarding.

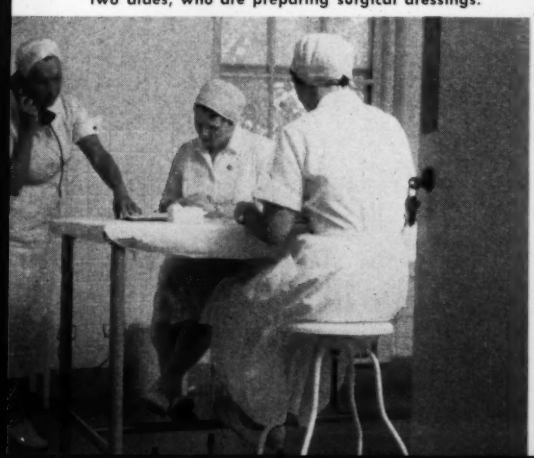
HER TRAINING as a nurse helps Superintendent Liala I. Johanson (right) of Lake Forest (Ill.) Hospital "talk the language" when problems involving medical and paramedical functions arise. Here she is engaged in informal discussion of a problem with the part-time radiologist and pathologist.

IN A CONFERENCE with the medical records librarian, Miss Johanson compares a nurse's report on a patient's fall from his bed with the patient's record, to make sure that all details of the incident are recorded.

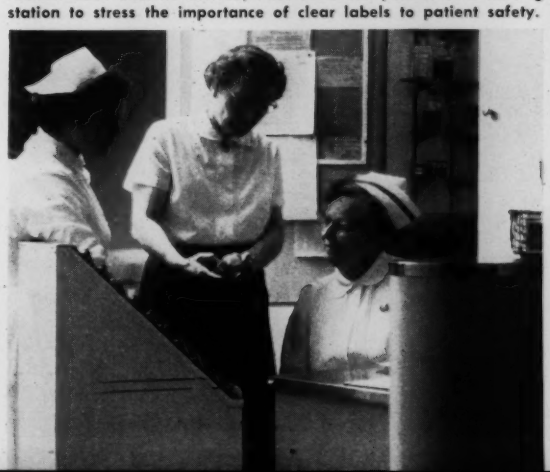
IN HER ROLE as hospital purchasing agent, Miss Johanson consults informally with the director of nursing on a new elastic bandage being tested. Daily conferences with the nursing director keeps her abreast of problems.

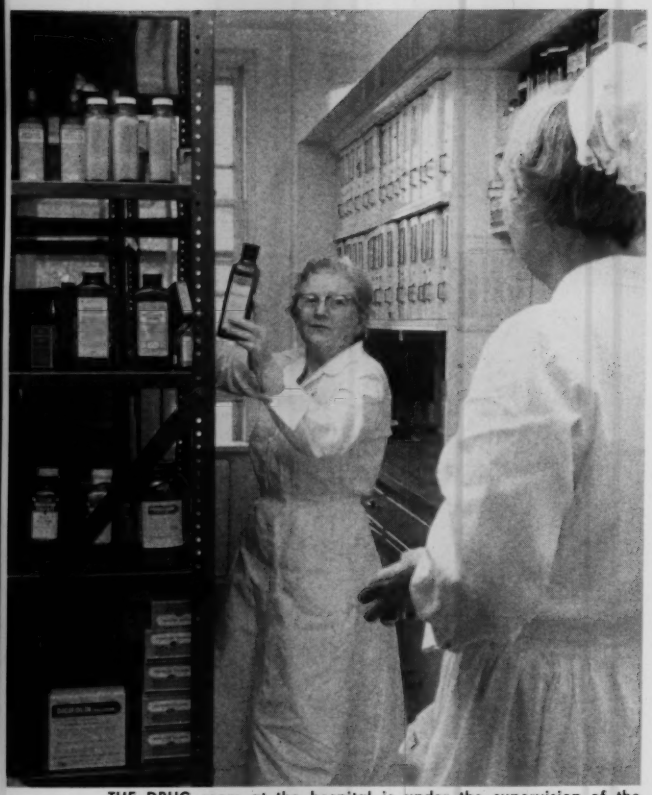


(ABOVE) The operating room supervisor at Lake Forest Hospital also serves as central service supervisor. Here she records the storage of intravenous solutions. (BELOW) In an adjacent room which is part of the central service department, the OR supervisor oversees the work of two aides, who are preparing surgical dressings.



(ABOVE) Continuing her investigation of the patient fall in the room where it occurred, Miss Johanson talks with the nurse who submitted the report, going over details to establish whether or not any negligence on the part of the hospital could be construed. (BELOW) Noting that labels on plastic bottles in a medications basket have become blurred, Miss Johanson pauses at a nursing station to stress the importance of clear labels to patient safety.





THE DRUG room at the hospital is under the supervision of the director of nursing. Here she releases drugs to a floor nurse. All compounding is done by arrangement with local retail pharmacists.

THE ASSISTANT director of nursing at Lake Forest Hospital is in charge of the instruction program for nursing aides. Here she is demonstrating bed preparation for a first-day student.

BECAUSE of the small size of the hospital, members of the medical and paramedical staffs are able to maintain relationships with patients on a personal rather than room-number basis. Here a doctor and the dietitian discuss a special diet with a patient.

a new concept of the medical audit

by ROBERT S. MYERS, M.D., F.A.C.S.

The author states the reasons why hospitals should do a continuing and adequate medical audit, and discusses a new method of accomplishing this objective originated by the American College of Surgeons and the Commission on Professional and Hospital Activities, Inc.

IF THE FINANCIAL records of any hospital were audited as casually and as ineffectively as is the quality of its patient care, the administrator and the governing board would probably land in jail. Or barring such an unfortunate happenstance, the least they could hope for would be financial chaos, unpaid bills and a richly deserved reputation for business incompetence.

Actually, there is much more reason to do a continuing and adequate medical audit in a hospital than there is to keep meticulous and informative financial records. The medical audit deals with the life and health of people; the financial audit is concerned only with money.

Be that as it may, except for rare and isolated instances, an effective and adequate evaluation of the quality of patient care has been nonexistent in the past. The chief reason for this has been the failure of organized medicine to develop a method of medical evaluation which could keep pace with the swift scientific advances of the medical profession during the first half of the Twentieth Century. The medical staffs and administrators of hospitals have long desired a practicable and effective medical audit.

The first organized attempt to inaugurate continuing and regular evaluation of the quality of patient care came from the American College of Surgeons when it launched the program of hospital standardization in 1918. This program was based on a set of minimum standards which had to be met by hospitals seeking the approval of the college. These standards required that a form of medical audit be done at regular intervals by the medical staff of the hospital as stated in the original standards: "That the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery, and obstetrics; the clinical records of patients, free and pay, to be the basis for such review and analysis."

It must be admitted, however, that the review of the clinical work as done by hospitals seeking the approval of the college fell far short of an adequate medical audit. The usual review consisted of a quantitative check by the record librarian, a rapid and superficial spot-check of a few records by the staff records committee, and a polite, restrained discussion at the monthly staff meeting of the noncontroversial aspects of the care of one or two interesting patients.

This is more or less true of the review of the professional work as done presently by hospitals accredited by the Joint Commission on Accreditation of Hospitals with this exception: the tissue committee of the medical staff, as originated by the college in 1951, is now functioning adequately in many hospitals and provides an evaluation of one phase of patient care—the justification for surgery.

HOSPITALS TEST METHOD

Recognizing the need for an effective and practicable method of evaluating patient care, the American College of Surgeons, in conjunction with the Commission on Professional and Hospital Activities, Inc., has been engaged since 1953 in a research program* to develop an adequate medical audit. A satisfactory method has been devised and has been demonstrated to be reliable and practicable after extensive use by the medical staffs of a pilot group of typical community hospitals.

The college's method has been studied by the Joint Commission on Accreditation of Hospitals which judged it to be an acceptable substitute for part of the activities of the tissue and medical record committees, the functions of which are a requirement for accreditation.

Here are the salient features of the college's new medical audit method:

● **It evaluates the critical criteria** of the three important aspects of the care of every hospital patient (medical, surgical, obstetrical):

Robert S. Myers, M.D., F.A.C.S., is assistant director, American College of Surgeons and treasurer of the Commission on Professional and Hospital Activities, Inc.

*Supported by a grant from the W. K. Kellogg Foundation, Battle Creek, Mich.

MEDICAL AUDIT CHECK SHEET

AMERICAN COLLEGE OF SURGEONS and the COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES, INC.

RECORD LIBRARIAN: DO NOT FILE THIS SHEET WITH PATIENT'S CHART

1. HOSPITAL	2. DATE OF DISCHARGE (month year)	3. HOSPITAL NUMBER	4. LENGTH OF STAY, DAYS	5. AGE ON ADMISSION	6. SEX	7. PHYSICIAN ATTENDING or OPERATING SURGEON	8. ADMISSION EVALUATION (optional)
C 2	4 6	1 5 9 5 6	2 1	5 4	2	* 1 6	1. Elective-properly classified 2. Elective-not properly classified 3. Emergency-properly classified 4. Emergency-not properly classified

9a. DIAGNOSIS BEING* EVALUATED	Myocardial infarction	4 2 0 • 1	11. HOSPITAL SERVICES AND PATIENT 1. Satisfactory 2. Lab not satisfactory 3. X-ray not satisfactory 4. Nursing not satisfactory 5. Combination of above 6. Patient or family not cooperative 7. Combination of patient and hospital 1
9b. OTHER SIGNIFICANT* DIAGNOSIS	Diabetes mellitus	2 6 0 • 0	

10. THIS chart was not further reviewed because:

12. INVESTIGATION BY PHYSICIAN AS RECORDED
1. Adequate or not indicated
2. Insufficient
3. Excessive
4. Inappropriate
5. No record in chart

(Enter code 1 for males in pelvic and menstrual history)

pertinent history	menstrual history	substantiating physical findings	blood pressure	heart	lungs	pelvic	rectal	reasonable progress notes	x-rays	laboratory	special studies
2	2	1	1	1	1	1	1	1	1	1	1

13. CONSULTATIONS
1. None necessary
2. Desirable and recorded
3. Desirable but not recorded
4. Required by staff rules and recorded
5. Required by staff rules and not recorded
1

14. OPERATION° None

BEING EVALUATED

Was operation fully described? 1. Yes 2. No

Was the correct procedure done? 1. Yes 2. No

Was operation justified? 1. Yes 2. No

Was surgery improperly withheld by medical staff? 3. Yes

Was operation refused? 4. Yes

15. DRUGS
0. Properly withheld
1. Properly given
2. Improperly withheld
3. Too much given
4. Too little given
5. Given inappropriately
6. Given when contraindicated

anti-biotics	anti-bacterial chemother.	narcotics	sedatives	cardiac regulators	anti-coagulants	whole blood	fluids and electrolytes	oxygen definitive therapy
0	0	1	1	0	1	0	0	0

16. HOSPITALIZATION
1. Adequate
2. Insufficient
3. Excessive
4. Inappropriate
5. Delayed
6. Delayed + 2 or 3
1

If not adequate, responsibility of:
1. Physician
2. Surgeon
3. X-ray
4. Laboratory
5. Operating room
6. Social circumstance
7. Patient request
8. Hospital request
9. Other

17. COMPLICATIONS
If present, write in as well as code:

1. No complications
2. Justified complications
3. Not justified complications
1

18. DEATH
Type:
1. Operative-surgery
2. Operative-anesthesia
3. Post-operative-surgery
4. Post-operative-anesthesia
5. Maternal, other than 1 to 4
6. Adverse reaction to drug therapy
7. Other

Evaluation:
1. Justified-autopsy
2. Justified-no autopsy
3. Probably justified-autopsy
4. Probably justified-no autopsy
5. Probably not justified-autopsy
6. Probably not justified-no autopsy
7. Not justified-autopsy
8. Not justified-no autopsy

Write immediate cause of death & "due to" in remarks

19. GENERAL MANAGEMENT OF PATIENT
1. Exceptional (reserved for unusual patients)
2. Adequate
3. Fair
4. Poor

Any grade below 2. requires committee opinion.
2

REMARKS: (Additional remarks are written on the reverse side of the hospital copy.)

figure 1

(1) hospitalization, (2) investigation (diagnostic work-up), and (3) treatment. A special Medical Audit Check Sheet has been devised for this purpose.

● **It is designed for use by the medical staff** of the hospital. This is essential, for if evaluation is to be accomplished and is to have any value, it must be done by physicians on the staff of the hospital. The college's method is suitable for use by any hospital regardless of type, size, and location.

● **It requires the thorough evaluation** monthly of only a limited number of selected groups of patient discharges. It has long been apparent that it is not possible for busy, practicing physicians to evaluate thoroughly the care of every patient discharged from the hospital. It seems logical, therefore, to select sensitive areas of patient care and to evaluate adequately a significant number of cases in these areas. The college's pilot group of hospitals has found that the evaluation of approximately 10 per cent of the monthly patient discharges has been satisfactory. The use of business machines to process the data obtained by the physicians' evaluations has also resulted in a considerable saving of time and effort.

● **It affords participating hospitals a comparison** of the variations in the diagnosis and treatment of identical diseases and operations. Reports of two types are returned to each participating hospital:

(1) A summary of the hospital's own audit findings, prepared by business machines in such a manner that the medical staff can easily see the scope of its auditing activity and the strengths and weaknesses of its medical practices as judged by its own audit committee.

(2) A comparison of the auditing experiences of the group of participating hospitals, assembled on an anonymous basis so that the medical staff of any hospital may see how its auditing activity and evaluations compare with those of the other hospitals in the program. Such comparison stimulates physicians to discover the reasons for variations between hospitals in the care of patients with similar disease conditions.

● **It has as its sole aim the improvement** of the quality of patient care. The comparison of auditing data offers a form of postgraduate medical education previously not available to medical staffs.

COMMITTEE PROCEDURE

As used by our group of participating hospitals, the college's medical audit method works this way: each month the medical audit committee of each participating hospi-

tal audits every death in addition to a sample of certain selected categories of diseases and operations. The schedule for 1957— prepared with the assistance of an advisory audit committee composed of physicians from the medical staffs of certain of the participating hospitals — includes the auditing during the first quarter of 1957 of a representative series of primary appendectomies; the auditing during the second quarter of the year of a representative series of premature infants; the auditing of diabetes during the third quarter; and complicated deliveries during the fourth quarter. In addition, the schedule has provided for a more detailed study of coronary occlusions, hysterectomies, and bleeding duodenal ulcers. In these special evaluations, additional clinical information is recorded by the audit committee and analyzed in a type of clinical investigation.

Following completion of the Medical Audit Check Sheets, they are mailed to the commission's headquarters in Ann Arbor, Mich., where they are processed by business machine methods; and the resulting information, categorized by disease and operation and coded to conceal the identity of hospitals and physicians, is returned to the participating hospitals.

CHECK SHEET BASIC

The Medical Audit Check Sheet, which permits rapid recording of the physician's evaluation of pertinent aspects of the care of an individual patient, is the basis of the college's audit method. The sheet is completed in duplicate; one copy is retained by the hospital for the information of the medical staff, and the other is sent to the commission. Figure 1, page 50, illustrates the use of the Medical Audit Check Sheet in the evaluation of a patient with a myocardial infarction due to coronary occlusion.

Figure 1 records the evaluation of the care of a 54-year-old female (item 6, sex; 2=female, 1=male) with a final diagnosis of myocardial infarction; diabetes mellitus was a secondary diagnosis. The patient's history was not recorded satisfactorily, but other aspects of the investigation (item 12) were judged adequate. Consultation was not necessary; surgery was not done; and medical treatment was adequate: narcotics, sedatives, and anticoagulants were indicated and given properly; other medications were not indicated and not given. The patient was hospitalized for 21 days (item 4) which was adequate (item 16). There were no complications, and the patient was discharged alive. General management (item 19) was judged to be *adequate,* which is the expected management of the usual case. *Exceptional* management is reserved for the exceptional case in which the entire management of the case indicates unusual skill. *Fair* indicates a minor degree of sub-par management. *Poor* is reserved for gross mismanagement of the case.

Items 1 to 7 and the coding in items 9 and 14 are completed by the medical record librarian; these are factual data not requiring the judgment of physicians. All other items are completed by the physician.

It should be noted that the hospital, patient, and physician are identified only by a code which is available only to the chairman of the medical audit committee of the hospital's medical staff.

Two items were crossed off by the physician-evaluator as not pertinent to this particular case: item 8 — admission evaluation — which usually is not recorded by hospitals, and item 18—death—which does not apply when the patient is discharged alive.

The use of business machines to process the data from the Medical Audit Check Sheets facilitates the presentation of two types of reports to each participating hospital: (1) the Medical Audit Summary (not illustrated here), in which the evaluations of individual patients can be read at a glance, and (2) comparisons of the auditing experiences of the group of participating hospitals.

COMPARATIVE REPORTS

Figure 2, below, illustrates one type of comparative report returned to 20 hospitals which participated in an evaluation of 519 patients with myocardial infarction, discharged from 20 hospitals during the year 1956. In Figure 2, which presents the use and criticism of the use of anticoagulants, all patients who died on the first hospital day were excluded; thus, 397 patients remained for the evaluation of the use of anticoagulants. The opinions presented are those recorded by the audit committee of each hospital's medical staff.

From the data presented in Figure 2, it is apparent that there was a considerable difference in the use of anticoagulants in the treatment of myocardial infarction in those patients hospitalized in small hos-

(Continued on page 112)

figure 2

USE AND CRITICISM OF ANTICOAGULANTS IN PATIENTS WITH MYOCARDIAL INFARCTION* BY HOSPITAL GROUPS

HOSPITAL GROUPS	NUMBER OF HOSPITALS	COMMENTS ON ANTICOAGULANTS				
		PROPERLY GIVEN	PROPERLY WITHHELD	PROPERLY GIVEN	CRITICISMS	
		Number of patients	Number of patients	Per cent	Number	Per cent
Small hospitals	8	39	33	54	7	10
Moderate size hospitals	5	52	31	63	8	10
Medium-large hospitals**	4	30	63	32	15	16
Large hospitals	3	135	14	91	11	7
ALL HOSPITALS	20	256	141	64	41	10

*Excludes patients who died on the first hospital day.

**One hospital, which gives very few patients anticoagulants, contributed over half of the patients to this group

Small hospitals = Less than 5,000 yearly discharges
Moderate size hospitals = 5,000 to 9,000 yearly discharges
Medium-large hospitals = 10,000 to 14,000 yearly discharges
Large hospitals = 15,000 and more yearly discharges

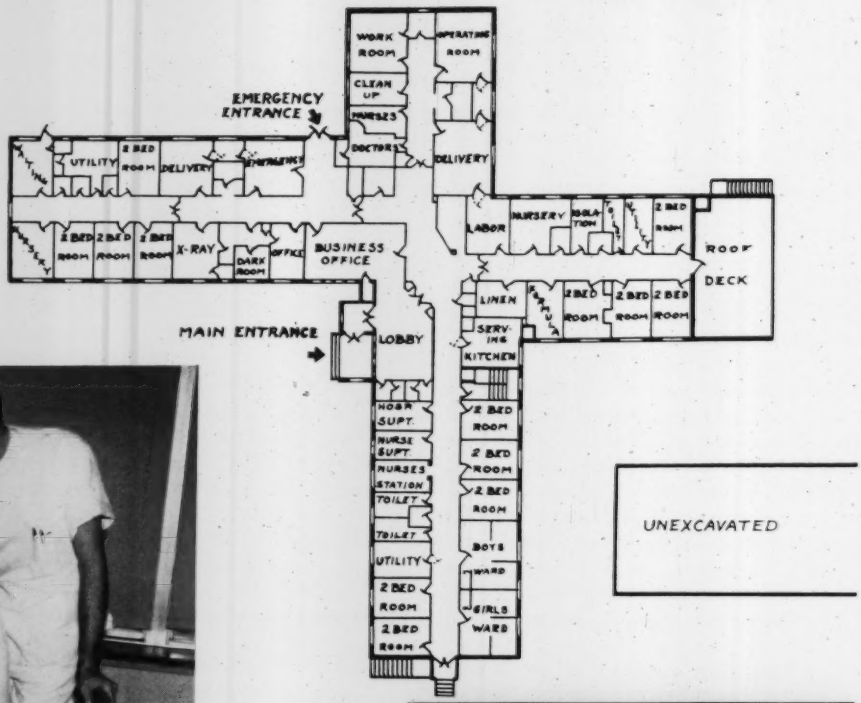
medical and paramedical aspects

of

the smaller hospital

for maximum

divided



THE hospital's part-time radiologist and the chief x-ray technician cooperate in taking and interpreting the 600 x-rays done monthly at the hospital.

The author describes the layout and function of the supporting areas of a smaller hospital, emphasizing the active part an administrator must play in the actual operation of the ancillary departments and the need for planning these areas carefully in the blueprint stage.

THE SUPPORTING areas of a small hospital are physically much the same as those in hospitals of any size; however, there is one important difference in the management of these departments.

The administrator and the director of nurses in the hospital with less than 50 beds form not only the hub around which the wheel revolves, but also furnish actual physical support for many of the spokes of the wheel.

The smaller hospital cannot afford to employ the full complement of qualified department heads necessary to the operation of larger hospitals; therefore, the administrator must be intimately acquainted with a wide variety of problems that would ordinarily be handled by the department head in a larger institution. For example, he is often called upon to participate actively in problems involving accounting and admission procedures, cleaning techniques, and equipment maintenance. With the possible exception of nursing personnel, the smaller hospital administrator as a rule handles the personnel management function. He nearly always is the purchasing agent and office manager, and in many instances may be chief housekeeper, chief engineer and laundry manager.

The director of nursing is frequently called upon to "fill in" in the accident room, delivery room, operating room or on the floor in addition to her routine duties of hiring and supervising nursing aides and orderlies and maintaining and distributing drugs from the pharmacy.

At Nanticoke Memorial Hospital, the administrator and director of nursing are currently being kept busy consulting with the building committee on the construction and equipping of a 28-bed addition.

THE consulting dietitian from the state board of health discusses the month's meals with Nanticoke Memorial Hospital's cook-manager.

Glenn A. Fisher is administrator, Nanticoke Memorial Hospital, Inc., Seaford, Del.

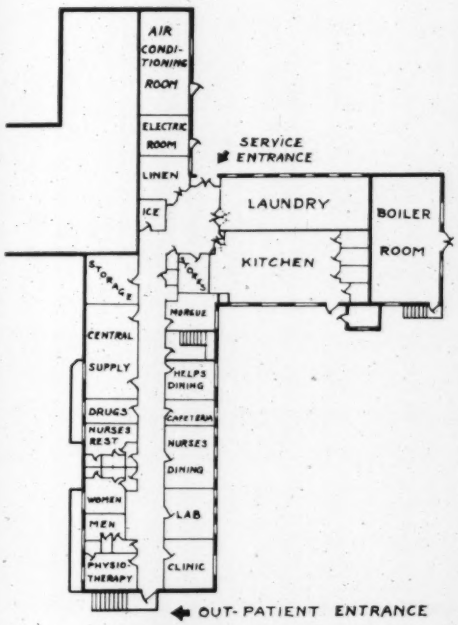
efficiency . . .

duties demand unified plant layout

by GLENN A. FISHER

Planning the location of the supporting areas in the physical plant —essential to the construction of any hospital—is especially important if the installation is less than 50 beds, because of the necessary proximity of the administrator to these departments.

The x-ray and laboratory departments in a small hospital are in many cases operated by the same personnel. When our hospital opened with 32 beds we assumed that one technician could handle both departments. Because the x-ray department is on one floor and the laboratory on another, however, we soon found ourselves faced with a problem.



Having expanded from 32 to 45 beds, we are now doing approximately 1,600 laboratory procedures and 600 x-rays per month, using three technicians and one aide. If these two departments had been located in adjacent areas we could produce much more work with much less effort: a telling argument for planning carefully in the blueprint stage.

Because the small hospital is seldom able to acquire the services of full-time pathologists or radiologists, most of this work must be "farmed out". We are fortunate to have the services of a radiologist three days a week and a pathologist at least once a week. All tissues are sent to the pathologist daily and x-rays are interpreted at the hospital by the radiologist.

In the dietary department of our hospital we found again the necessity for more efficient planning. The dining rooms for hospital personnel, which must be served by the dietary department, are too far from the kitchen, making it necessary to employ more help than would be needed if they were more conveniently located.

We have found that serving food in bulk from the kitchen via dumbwaiter to a steam table on the upper floor (where it is portioned onto trays and delivered to the patients on unheated carts) is the most successful food service method.

It is usually economically impossible for a small hospital to employ a qualified dietitian. Most smaller hospitals employ a good cook who has had some experience in buying and managing large quantities of food. For the preparation of special diets we rely on the cooperation of our own nurses and members of our medical staff. We are fortunate in that the Delaware department of public health employs a consulting dietitian whose services are available to us through the medium of monthly visits when she reviews our operations, checks menus and answers

(Continued on page 112)

IN ADDITION to her regular nursing and supervisory duties, the obstetrical supervisor at Nanticoke Memorial Hospital also assists in training nursing aides. Here she observes a nursing aide who is learning how to set up blood pressure testing apparatus.

LIKE many smaller hospitals, Nanticoke Memorial Hospital does not utilize the full-time services of a pathologist. Here the pathologist who visits the hospital at least once a week examines tissues under the microscope while members of the full-time staff assist.

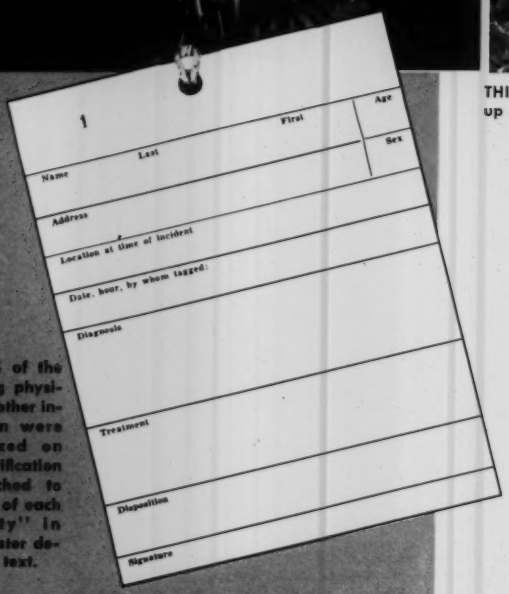
role of the medical staff in

• *emergency service*

• *mass casualty handling*

by JAMES H. IRWIN

THIS is an example of the amateur radio communications center that was set up near the receiving center during a simulated mass casualty situation.



FINDINGS of the examining physician and other information were summarized on an identification tag attached to the wrist of each "casualty" in mock disaster described in text.

THE NEED for adequate emergency care has greatly increased as a result of present-day interest in sports, cars, and do-it-yourself activities, and will continue to increase as more leisure time becomes available through shorter work weeks.

The public is rapidly learning that hospitals have emergency service at all hours and that no matter what overtakes them, the hospital emergency room is open to receive them and to give them the best in medical care. As a result of this dependence by the public, the hospital emergency service is finding its scope extended to take care of many general medical and surgical problems.

The hospital's professional reputation often is at

James H. Irwin is administrator of Monmouth (Ill.) Hospital.

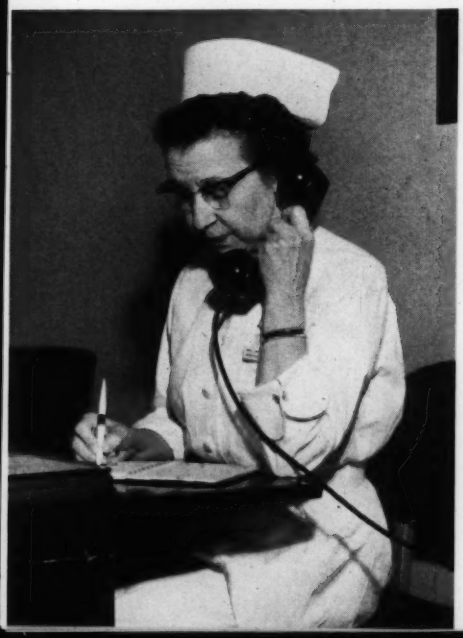
In providing a hospital emergency service and a workable plan for caring for mass casualties, the primary factor is not the size of the institution but the quality of medical care that can be rendered, this author points out. For this reason, the entire medical staff should be included in the planning and execution of these services.

stake in the way in which it conducts its emergency unit. Regardless of the size of the hospital, this unit must be integrated with the hospital organization as well as with the entire medical staff. It is not size but the effectiveness of the medical care that is important.

The efficiency of the emergency room depends upon the medical staff, the nurses, and the accessibility of facilities and equipment. A doctor must be on call for the emergency room 24 hours a day, as delays during the period of tension and uncertainty provoke criticism no matter how excellent the final medical care may be.

When a patient arrives, he is taken immediately to the emergency room, ideally located in the vicinity of the operating room, laboratory, and x-ray departments. Here diagnostic facilities are available, along with a resuscitator and oxygen for emergency treatment. If the patient requests his family physician, he is called at once. If he is not available or if the patient has no preference, the physician on call is summoned for service.

THE director of nurses contacts the receiving center during the mass casualty exercises.



Although one doctor is on call at all times, the entire medical staff has a definite part in any emergency. If the doctor orders x-rays, an x-ray technician is called out. If laboratory tests are to be made, this technician is sent for. If the use of the operating room facilities is required, operating room personnel are called. The doctor on call, of course, may ask for any other doctors on the staff whose services he feels are necessary. The doctor, too, will determine if the patient is to be discharged after diagnosis and treatment or is to be admitted as a bed patient in the hospital.

Basically, an emergency service organized to meet the common medical and surgical needs of any community will be the same whether in urban or rural, acute or chronic disease hospitals. Nor does the type of ownership of the hospital, whether public, fraternal or proprietary, change the method of rendering emergency room care.

Each member of the medical staff is given a choice as to whether or not he will be on call. The older doctors generally leave the emergency work to the younger doctors; however, they are quickly available in case a mass casualty occurs. Doctors in the outlying districts do not take emergency calls at the hospital, since they serve the area surrounding them from their offices. If hospital care is needed, they accompany the patient to the hospital.

On-call notices are posted weekly two or three weeks in advance. The doctor listed first one week takes the bottom of the list the following week; in this way, all doctors have an equal first call load to carry. These notices are posted in the admitting office, on the doctors' bulletin board, in the medical records room, director of nurses office, surgery, and in the doctors' dressing room.

Adequate record keeping is important in good emergency room care. The nature of the injury, treatment given, and other pertinent facts concerning the patient should be properly recorded. Very often there are legal implications in emergency room admissions; for this reason particularly the records should be made an integral part of the hospital medical records.

The regular inpatient operative record is used for emergency patient care. This record gives complete detail as to diagnosis, condition of patient, anesthetic given, operation performed, and findings.

UNIT MUST BE FLEXIBLE

A well organized emergency unit should be readily expandable into a facility to care for mass casualties. The primary requisite of a disaster plan is that it be flexible to the extent that it can be quickly adapted to meet any situation. Realistic planning must begin with the organization of all community groups. The over-all organization of the disaster plan is coordinated into one main casualty program to function as a unit in the event of a disaster.

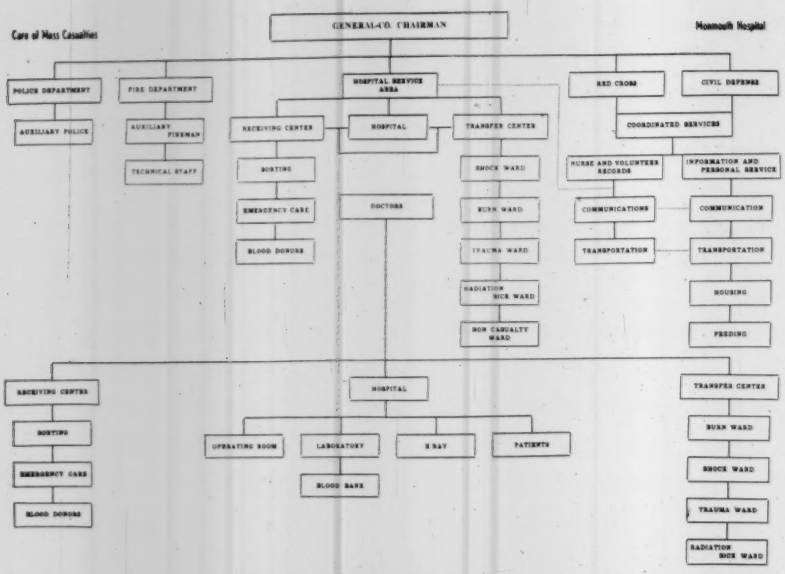
Observations in the following paragraphs on the work of the hospital medical staff and other hospital and community groups during a mass casualty situation are based on a mock disaster operation staged recently in the community of Monmouth, Ill. The exercise demonstrated the need for close coordination of the community's medical resources and law enforcement and rescue agencies in dealing with a disaster involving large numbers of casualties.

The first community organization to be ready for action in case of a disaster is the police department. The primary responsibility of the police department is to control traffic and to keep crowds away from the scene of the disaster. This necessitates roping off the disaster area and controlling traffic on main highways leading to the scene. The police department also forms a connecting link with the state police and other law enforcement agencies of the area. In this way the disaster area is completely under the supervision of the law.

Fire department personnel, all trained in first aid and evacuation procedures, enter the scene of disaster and go to work rescuing the injured.

MOBILIZE HOSPITAL AREA

It is of utmost importance that the area surrounding the hospital be planned for specific uses. The existing hospital and emergency



organizational chart for care of mass casualties

service must be able to be expanded to an improvised hospital and transfer center, and the hospital must be kept informed at all times of the extent and nature of the disaster. The key to this successful expansion is communication. Any amateur radio operators should be directed to set up portable radio receiving and sending sets immediately.

Upon notification by a prearranged signal, all chairmen of the service committees, with the exception of the hospital administrator, should report to a central location to get information as to the location and extent of the disaster. The respective committee chairmen start their duties at once. Mobile radio sending and receiving squads are immediately dispatched. One goes to the scene of the disaster, one to the receiving center, and one to the transfer center.

The hospital service area, as shown on the chart, can communicate with the scene of the disaster by means of the mobile unit. Short-wave radio should be installed in the administrator's office to keep him informed of all happenings.

Upon notification of the possible number of people involved in the disaster, the hospital organization goes into action. The director of nurses should check off all nurses on duty from the register of community nurses and give the register to hospital office personnel, who go immediately to the receiving center and set up an information service and a nurses and volunteer personnel service.

MEDICAL STAFF ASSEMBLED

The hospital medical staff, which assembled upon notification of the disaster, hears the report of the possible number of casualties. The doctors then go to their assigned places at the hospital service area, the transfer center, and the receiving center, which is the emergency service of the hospital transferred to a nearby building previously designated for such use. This emergency service should comprise an emergency examining table, sterile and other supplies, laboratory, portable x-ray, and a morgue.

RECEIVING CASUALTIES

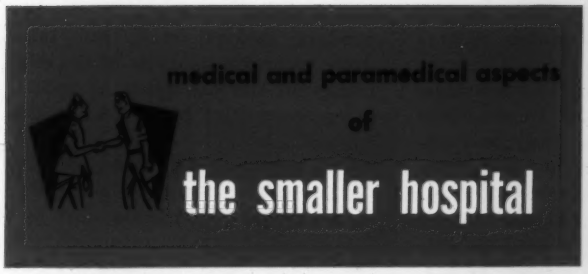
The emergency room, operating room, x-ray, and laboratory in the main hospital should be fully staffed to receive casualties sent from the receiving center. To facilitate the transfer, police should take up positions at the entrance to the hospital and at the emergency entrance, in order to restrict entry of all persons except patients, hospital personnel and relatives of patients.

In most cases, the Red Cross will be actively engaged in transportation and first aid work. When the mobile unit of communication, traveling over the disaster area,

(Continued on page 112)

A NURSE applies a numbered identification band to a "casualty." The number corresponds to that on the patient's disaster tag.

A LITTER can be used for a cot as shown here, enabling casualties to be cared for without unnecessary handling or confusion during emergencies.



medical staff organization:

less complex in the smaller hospital—but no less important

by DABNEY P. GILLILAND

Using the standards for hospital accreditation developed by the Joint Commission on Accreditation of Hospitals as a basic guide, the author discusses some of the variations in medical staff organization found in smaller hospitals.

IN DISCUSSING medical staff organization in any hospital operation, several facts which are often taken for granted should be emphasized.

First, in its endeavor to carry out the functions of the hospital, the governing board has the authority and responsibility of ownership, dedicated to the welfare of the community. Realizing this, the medical staff is then responsible to the governing board for the quality of all medical care rendered in the hospital and for ethical standards of procedure.

Second, recognizing that the best interests of the patient are protected by concerted effort, the physicians organize themselves into a self-appraising medical staff, subject to the hospital policies of the governing board in rendering medical care to patients admitted to the hospital.

Third, the medical staff assists in meeting and maintaining the standards of the hospital as approved by the Joint Commission on Accreditation of Hospitals; members associate themselves with such other national, regional, or local organizations, as may be indicated, whose interests are maintaining a high level of patient care.

With these generalities in mind, we can now proceed to specific observations regarding medical staff organization in the smaller hospital. All comments will not apply to every hospital, due to local situations and interests, but variations may be applicable.

Dabney P. Gilliland is administrator of General Hospital, Greenville, Miss.

LESS HIGHLY ORGANIZED

Basically, medical staff organization in the smaller hospital is the same as in a large hospital, except that it is carried out to a lesser degree — fewer physicians, fewer committees, less specialization, less separately organized clinical departments. The section relative to the medical staff in the standards of hospital accreditation as developed by the Joint Commission on Accreditation of Hospitals is recommended as a basic guide. Requirements should be met, but beyond that the degree of organization will depend upon local conditions.

In all instances, membership on the medical staff should be restricted to physicians who are graduates of approved schools of medicine, in good standing, and legally licensed to practice in the state in which the hospital is located. Application for admission should be submitted on the prescribed form and upon recommendation of the credentials committee, approval of the medical staff, and appointment by the governing board, and should be maintained for future reference.

Appointment to the medical staff should not automatically confer unlimited professional privileges on the appointee; rather, privileges should be recommended by the credentials committee. When major surgical privileges are requested, "sponsorship" is recommended, if it is available. Such sponsorship should require the actual presence of the sponsor (a senior surgeon) until such time as he becomes satisfied regarding the quality of the work of the one being sponsored.

SEVERAL DIVISIONS

The medical staff may have several divisions, as indicated by local needs. The active staff, courtesy staff, honorary staff and consulting staff are recommended divisions; their titles are indicative of their status in the organization.

All officers should be elected from the active staff for a term of one year. Officers should in-

clude a president or chief, a vice president or vice chief, and a secretary and other such officers as may be necessary for proper government of the staff.

In the very small hospital some physicians will be officers of the staff and at the same time serve on several of its committees. In fact, it may be advisable to have the entire active staff serve as a committee of the whole for transaction of business and delegating specific duties to the members. Regardless of the method chosen, recommended committees are the executive, credentials, joint-conference, medical records, and tissue. All committees are appointed by the chief of staff, with the exception of the executive committee and possibly the credentials committee, which are elective. Briefly, the duties of these committees should be allocated as follows:

Executive Committee. Considers and acts upon all matters which are not of a clinical nature. It is anticipated that such business of the medical staff will be transacted by the executive committee in order that the time of the regular meetings may be devoted to matters pertaining to the professional care of patients. In the very small hospital the executive committee may also assume the duties of the joint-conference committee.

Credentials Committee. Investigates the credentials of all applicants for membership on the medical staff, and makes recommendations thereon.

Joint-Conference Committee. Represents the staff in meetings with the governing body and administration of the hospital.

Medical Records Committee. Supervises and appraises all medical records to insure their maintenance at the required standard. It is suggested that a time limit for the completion of medical records be initiated in order to insure that the medical records will not become extremely delinquent.

Tissue Committee. Studies and reports to the staff or to the proper committee the agreement or disagreement between preoperative diagnoses and the report by the pathologist on the tissues removed at operation.

FREQUENCY OF MEETINGS

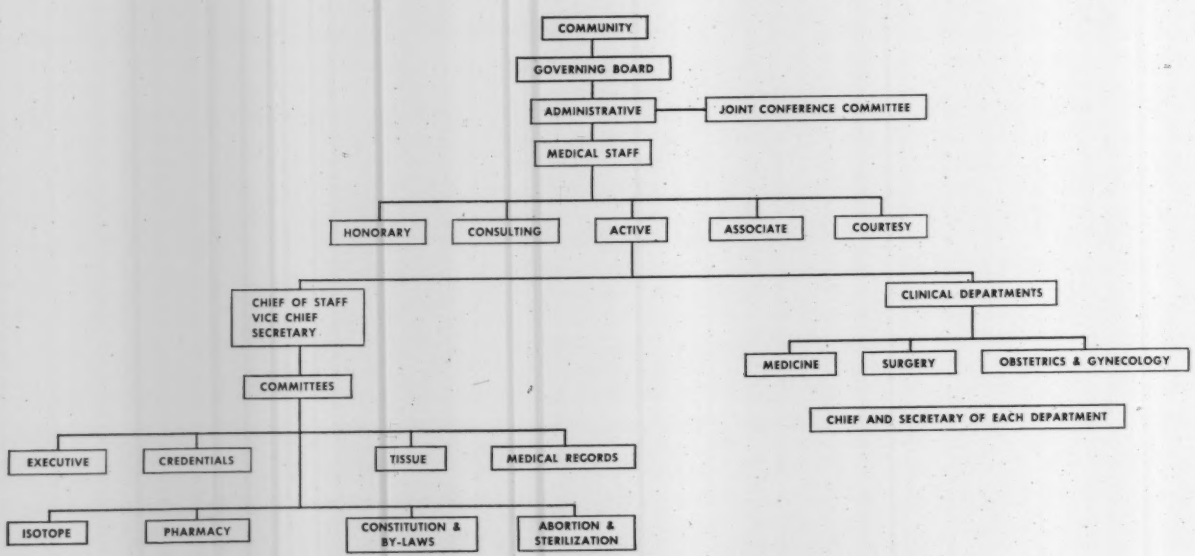
All committees should meet often enough to properly perform the work delegated to them. In all instances the executive committee, medical records committee, and tissue committee should meet at least once a month.

At the minimum, the active medical staff should be divided into medical and surgical clinical departments. Such other services as the size and degree of specialization of the medical staff may warrant should also be included. Assignment to the various departments should be made by the attending medical staff, but only after a careful analysis of the efficiency of the candidate as shown by a record of his work in the hospital.

Rules and regulations of the medical staff should be a supplement to its constitution and bylaws, and should contain sufficient regulations so as to insure the fulfillment of the constitution and bylaws, the proper care of the patient, and a harmonious working relationship between the medical staff and the administration of the hospital.

To summarize, the medical staff is organized so as to insure that all patients receive the best possible care; to provide a means whereby problems of a medico-administrative nature may be discussed by the medical staff with the governing board and administration; to initiate and maintain self-government; and to provide education and maintain education standards.

In all aspects of hospital operation the patient is the first consideration. Granted, the physicians and the hospital receive indirect benefits from medical staff organization, but the direct benefits of an organized, self-appraising, self-governing medical staff, functioning within the policies established by the hospital governing board, belong to the public it serves. ■



MEDICAL STAFF ORGANIZATION AT THE GENERAL HOSPITAL, GREENVILLE, MISS.

your president reports

I HAVE RECENTLY had an experience by which two completely separate study projects have suddenly coincided in such a manner that they have emphasized a new concept of the traditional hospital nursing unit. The hospital nursing unit has now become the hospital patient care unit and this change in terminology illustrates a definite change in attitude, thinking and philosophy toward this most important functional and structural component of the hospital.

The first approach occurred during the preliminary planning of a research program in hospital function and design made possible through a Public Health Service research grant. A decision was reached in consultation with the advisory committee of the research project that the typical nursing unit of the hospital was of fundamental importance in planning hospitals and that this area of the hospital should receive priority in study.

However, when the research staff met with the administration and nurses of the hospital to develop this study—it was immediately obvious that there was much more involved than just nurses and administration. The important influence of the attending physicians —not only in their care of patients, but in their use of the facilities; the inter-relationship of the other personnel such as dietitians, technicians, social workers, and housekeeping and maintenance personnel having contacts with patients; as well as the needs and reactions of the most important individual concerned—the patient —all emphasized that the terminology and habits of thought regarding the nursing unit should be changed.

Instead of referring to the nursing care division alone, it was necessary to broaden the term to the patient care division of the hospital. Nursing, of course, is a most important component of this patient care division.

THE SECOND approach came about as the result of a concern on the part of hospitals for the recruitment and supply of nursing personnel in hospitals. A study was suggested. It was evident that nursing leaders shared this concern—but there appears to be a considerable lack of enthusiasm to any proposed study of nurses by hospitals. The objections were not so much against the suggestion that facts and knowledge should be obtained by which future policies or programs regarding nursing could be decided but it was emphasized again and again that nursing or nurses could not be studied as isolated units. Their relationship with physicians, with other hospital personnel, with administrators—and, most importantly, with patients—requires that we regard nursing as an important component of total patient care.

I do not believe that we are falling into a trap of psychological semantics when we emphasize a patient care division or patient care instead of nursing care. Modern hospital and medical care is far more complex and interrelated than it was in the past and it is important that we realize that the team or multi-discipline approach is mandatory today.

If we must focus our thinking, it should be on the central object —the patient. All of the hospital and medical disciplines are more or less dependent upon each other and it would thus seem logical to emphasize the patient care division and patient care itself. It should be pointed out, however, that such definitions or broadening of basic thinking does not preclude studies or research in any specific, isolated component such as nursing in a hospital. Obviously one can only do research or make studies by attacking one selected area at a time. However, if these individual studies are always regarded in relation to the whole composite of patient care, better understanding and cooperation will occur and constructive contributions will result.

Albert W. Snoke, M.D.

Albert W. Snoke, M.D., president
American Hospital Association

professional practice

the flexibility of code numbers used in *The Standard Nomenclature of Diseases and Operations* simplifies

group indexing in the smaller hospital

by DORIS GLEASON

The code numbers assigned to diseases and operations listed in *The Standard Nomenclature of Diseases and Operations* make the volume useful as an indexing tool to be used to varying degrees according to the size and needs of the hospital or clinic, the author states. All hospitals can profit from its use, the smaller ones in setting up simplified classification systems and the larger ones in developing highly complex systems.

The Standard Nomenclature of Diseases and Operations is more than a register of diseases and operations. Because numerical code numbers have been assigned to diseases and operations for the purpose of indexing, the volume also serves as a classification or indexing tool. The principles upon which the code numbers have been established make it possible for the book to be used effectively as an indexing tool in any hospital or clinic regardless of its size or type. It is possible within the framework of the coding arrangement to supply a distinct numerical code number for each of the 16,000 or more diseases listed within the body of the book. Naturally this maximum use of the listing is practical only for a limited number of large teaching and research hospitals.

It is entirely possible, however, for diseases or operations having the same etiological condition or procedure to be grouped on one card regardless of specific site (grouping by topography or site), or for diseases having the same site to be grouped on one card regardless of specific etiology or procedure (grouping by etiology).

Whether a hospital or clinic indexes to the finest degree or uses a system of group indexing depends entirely upon the demands which the index will be called upon to meet. Demands in the teaching or research hospital will differ from those in the smaller hospital; a system which will work effectively for one might be ineffective for the other. In other words, the index can be used to many different degrees. All hospitals can profit from its use, the larger ones in setting up highly detailed classification systems and the smaller ones less complex systems commensurate with their needs. The book is not as formidable as it might appear; the listing system lends itself extremely well to graduated use.

Doris Gleason, C.R.L., is executive director of the American Association of Medical Record Librarians.

STANDARD METHODS BEST

During the last few years more and more hospitals, including many large teaching hospitals, have adopted some method of group indexing. Experience has shown that indexing according to recognized grouping procedures produces an effective index in less posting time and at lower supplies and equipment cost.

A knowledge of the basic principle behind code numbers used in the *Standard Nomenclature* is a prerequisite for proper indexing. This principle is that "every disease is the result of a cause acting on organ or tissue of the body." Accordingly, diagnoses listed in the nomenclature have been classified according to topography (site) and etiology (cause). The two categories are separated by a hyphen and are completely distinct. The numbers left of the hyphen designate topography or site and the numbers right of the hyphen designate etiology or cause. In the nomenclature of operations, this principle has been maintained in that the numbers left of the hyphen still designate topography or site while the numbers right of the hyphen designate procedure.

In order to provide a separate code number for every disease listed in the nomenclature, thereby making it possible to index to the finest degree, it was necessary in some instances to expand the code numbers to 12 digits for one specific diagnosis.

In making the decision of how extensive the hospital's coding should be, it must be borne in mind that the disease code number must contain at least six digits—three left of the hyphen and three right of the hyphen. Also, the operation code number must contain at least five digits—three left of the hyphen and two right of the hyphen. The indexer must be certain that this six-digit code number appears on the disease index card, either as the main heading for the card or in the appropriate site or etiology columns. In the operation index the five-digit code number must appear on the operation index card either as the main heading for the card or in appropriate site or procedure columns.

SOME SYSTEMS TOO CONDENSED

In an effort to simplify the indexing of diseases and operations, many medical record librarians have used the numbering system of the *Standard Nomenclature* in developing various methods of grouping. Experience has shown, however, that some of these systems are so condensed that they cannot meet the demands put upon the index, while others are so complicated that it is difficult to train personnel in their use. Two systems of grouping which have proven effective both from the standpoint

NEW INTRAMUSCULAR IRON PROVIDES PRECISION THERAPY, PROMPT RESPONSE

IMFERON,® the new intramuscular iron-dextran complex, was introduced to American hematologists at the Sixth International Congress of the International Society of Hematology held in Boston, August 27 to September 1, 1956. Recent experience from over 6 million injections has shown that this iron preparation is easy to administer, notably free from toxic effects, quickly absorbed and productive of rapid hematologic and clinical improvement. It has been termed "...the only therapeutically effective iron preparation for intramuscular use...."[1]

IMFERON meets the need for a safe, effective agent when parenteral iron is preferable for patients with iron deficiency anemia who are resistant or intolerant to oral iron, those with depleted iron reserves and those who require rapid restoration of hemoglobin, *e.g.*, last trimester of pregnancy.

Previous parenteral iron preparations were unsatisfactory because of toxicity, pain on injection, or because they contained insufficient iron. IMFERON contains the equivalent of 5 per cent elemental iron. It is more stable than iron saccharate both *in vitro* and *in vivo* and does not precipitate in plasma over a wide pH range. It is isotonic with tissue fluids and has a pH of 5.2 to 6.0.[1] Utilization for hemoglobin formation is almost quantitative.

Precision Therapy with IMFERON: Before treating a patient with IMFERON, total iron requirement is calculated by formula or determined from a convenient dosage chart. Then appropriate amounts of IMFERON are injected daily or every other day, until the total calculated required amount is given.

Iron Deficiency Anemia of Infancy: IMFERON provides a convenient safe means for restoring hemoglobin levels and iron reserves in anemic infants. Excellent results were obtained by Gaisford and Jennison[2] with IMFERON in 100 iron-deficient infants. From a pretreatment average of 54.5 per cent, hemoglobin levels rose to 87 per cent 10 weeks after the start of therapy. Clinical improvement paralleled this response. Premature infants and surgical cases were similarly benefited. IMFERON gave "...all the advantages of transfusion or intravenous therapy without the disadvantages."[2] There were no side effects in any of the infants treated. Wallerstein[3] confirmed these results, furnishing evidence that IMFERON is well absorbed and appears in the bone marrow 12 to 24 hours after injection. Results are equal to those with intravenous saccharated iron oxide without the unpleasant side effects. Sturgeon[4] showed that the first year's iron requirements in infancy can be supplied with three injections of IMFERON.

Iron Deficiency Anemia of Pregnancy: Nausea precludes oral iron therapy in many anemic pregnant women. In those with severe anemia who are first seen late in pregnancy, prompt hemoglobin regeneration is unobtainable with oral iron. IMFERON produced prompt hemoglobin responses in anemia of pregnancy,[5,6] the results being similar to those obtained with intravenous saccharated iron oxide. Side effects were virtually absent with IMFERON.[5,6]

Resistant Hypochromic Anemia: Patients who do not respond to oral iron, those who cannot take oral iron and those with gastrointestinal pathology respond well to injections of IMFERON.[7-11] While oral iron is of little value in treating the anemia of rheumatoid arthritis, IMFERON is "...as beneficial as intravenous iron and easier to administer."[8]

Present Studies: Published reports and recent findings of clinical investigators confirm the effectiveness and safety of IMFERON for hemoglobin regeneration and creation of iron stores. More than 70 studies are now being completed in the United States. Reports stress prompt hemoglobin response, ease of administration and freedom from side effects. Clinicians desiring additional information should request Brochure No. NDA 17, IMFERON, Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin.

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of utilization and training purposes are: (1) grouping by master code topographic *or* master code etiologic code numbers, and (2) dual grouping by topographic and etiologic code numbers in the disease index, and dual grouping by topographic and procedure code numbers in the operation index.

Either of these systems may be adopted by hospitals or clinics of almost any size with the assurance that it will produce a workable index with a minimum amount of time and effort. Only in large teaching or research hospitals where the demands on the indexes warrant indexing to the minutest degree are these systems not practical.

Knowledge of the basic principles of the classification system used in *Standard Nomenclature* and a thorough understanding of material in the book itself are especially important when a system of group indexing is used. Persons who have not had the benefit of formal training in an approved school for medical record librarians should not attempt to group index until they have attended one of the institutes sponsored by the American Hospital Association and the American Association of Medical Record Librarians or the American Medical Association. In the event that such attendance is impossible, considerable study and attention should be given to the introduction on pages x-xii in the *Standard Nomenclature*.

MASTER CODE NUMBERS

Master code numbers have been used throughout the *Standard Nomenclature* for the sole purpose of reducing the size of the volume. Experience has shown, however, that using these master code numbers as they appear in the nomenclature enables one to group diseases by site or etiology and to group operations by site. There are examples in the nomenclature where master code numbers appear in both the topographic code number and etiologic code number for a specific disease or condition. Nevertheless, it is recommended that grouping *not* be used for both topography and etiology simultaneously unless a specially designed card (to be described presently) is employed.

Master codes are recognized by the fact that only the control digits referring to the system, organ, or part involved, or category or subdivision of the etiologic category involved, are given in the formation of a code number for a specific disease or operation. These control numbers are followed by one or two decimal points with instructions for the coder to specify complete site or etiology in accordance with the diagnosis or operation being coded. In other words, the coder must refer to pages 3-46 to complete the topographic master code number and to pages 49-81 to complete the etiologic master code number.

A search through the nomenclature will disclose that in many instances only the first digit of the topographic code number or etiologic code number has been given. Persons thoroughly familiar with the nomenclature may set up disease and operation indexes employing one-digit master topographic or master etiologic code numbers. Generally, however, it has been found that grouping by one-digit master code numbers tends to produce errors in recording information on specific cards and results in such broad grouping that the usefulness of the index is jeopardized. For this reason it is recommended that grouping by master code numbers be limited to diseases which have been assigned a two-digit topographic master code number. It is further recommended that grouping in the operation index be limited to operations which have been assigned a two-digit topographic master code number. This policy, it is true, places a limitation on the number of diseases and operations that may be grouped. After the system has been in effect at least six months, an audit of the cards may uncover instances where the frequency of specific diseases or operations warrants expansion of grouping beyond the two-digit master codes assigned in the nomenclature.

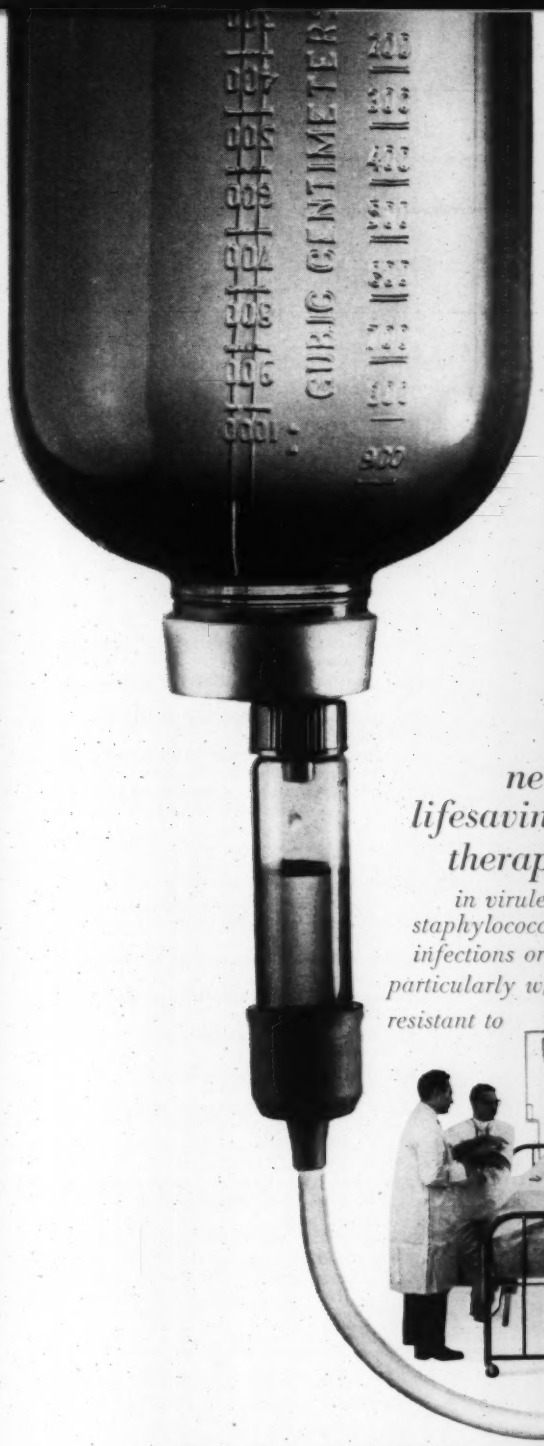
INDEX CARD SHOWS NUMBER

When the system of grouping by master code numbers is used, the index card will show the master code number as it appears in the nomenclature and the correct terminology. The correct terminology should be followed by the notation "Specify site" if the master code number appears in the topographic section or "Specify etiology" if the master code number appears in the etiologic section. The fact that the decimal point, designating the digit that is to be completed, appears in the index card points out quickly that grouping is being employed as an indexing procedure. The card itself has a column entitled "Site" for entering the complete topographic code number for the particular organ or part affected and a column entitled "Etiology" for recording the complete etiologic code number for the exact etiology. With these two columns the index card can be used whether the disease is being grouped by the two-digit topographic master code number or by the two-digit etiologic master code number. In no case should both of these columns be filled in on one card, as this would indicate that grouping was being done both by topographic and etiologic master code number. Here are some examples:

Diagnoses Appearing on Medical Records	*Code Numbers*
1. Arthritis of spine due to infection (Case No. 6241— Male, age 46. Result: Improved Dr. Jones	241-100
2. Arthritis of knee due to infection (Case No. 7639 — Female, age 55. Result: Improved Dr. Jones	248-100
3. Arthritis of wrist due to infection (Case No. 8001—Male, age 29. Result: Improved Dr. Black	244-100

On page 135 of the nomenclature the code number 24.-100 is given to the diagnosis "arthritis due to infection." Specify joint. In order for the coder to complete the topographic code numbers for the specific diagnoses listed above, it would have been necessary to refer to page 13 in the nomenclature for the specific code number for the vertebral joints, knee joint and wrist joint.

The three diagnoses listed above would have been grouped on one



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1. Baadj, A. G.; Corbin, E. E., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 72. **2.** Bernstein, A., and Piller, M.: Schweiz. med. Wchnschr. *86*:1247 (Nov. 3) 1956. **3.** Bünger, P., and Schütze, G.: Medizinische *51*:1811 (Dec. 22) 1956. Abstract: J.A.M.A. *163*:895 (March 9) 1957. **4.** Esselier, A. F., and Keith, J.: Schweiz. med. Wchnschr. *86*:1311 (Nov. 17) 1956. **5.** Marmell, M., and Prigot, A.: Antibiotic Med. & Clin. Therapy *3*:263 (Sept.) 1956. **6.** Marmell, M., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 44. **7.** Noyes, H. E.; Nagle, S. C., Jr.; Sanford, J. P., and Robbins, M. L.: Antibiotics & Chemother. *6*:450 (July) 1956. **8.** Ross, S.: Antibiotics Annual 1955-1956, New York, Medical Encyclopedia, Inc., 1956, p. 600. **9.** Siegenthaler, V. W.; Keiser, G., and Hegglin, R.: Deutsche med. Wchnschr. *81*:2074 (Dec.) 1956. **10.** Sobin, B. A.; English, A. R., and Celmer, W. D.: Antibiotics Annual 1954-1955, New York, Medical Encyclopedia, Inc., 1955, p. 827. **11.** Trafton, H. M., and Lind, H. E.: Antibiotic Med. & Clin. Therapy, in press.

DISEASE INDEX	CODE NO. 24.—100	DIAGNOSIS Arthritis due to infection (Specify joint)					
Hosp. No.	Sex	Age	Result	Site	Etiology	Operation	Physician
6241	M	46	I	241			Jones
7639	F	55	I	248			Jones
8001	M	29	I	244			Black

chart 1

disease index card as shown in Chart 1 above.

Diagnoses Appearing on Medical Records	*Numbers*
1. Chemical burn of breast due to iodine (Case No. 1641—Female, age 28. Result: Improved Dr. Brown	190-3218
2. Chemical burn of breast due to sulfuric acid (Case No. 2987—Male, age 39. Result: Improved Dr. Black	190-322

On page 122 of the nomenclature the diagnosis "chemical burn of breast" is given the code number 190-32. Specify poison. In order for the coder to complete the master etiologic code number it would have been necessary to refer to page 58 of the nomenclature for the specific code number for iodine and sulfuric acid.

The two diagnoses listed above would have been grouped on the disease index card as shown in Chart 2 below.

Operation Listed on Medical Record	*Code Number*
1. Manipulation of elbow joint (Case No. 7841—Male, age 14. Result: Improved Dr. White	243-80
2. Manipulation of wrist joint (Case No. 9991 — Female, age 24. Result: Improved Dr. Smith	244-80

On page 535 of the nomenclature the operation "manipulation of joint" is given the code number 24.-80. In order for the coder to complete the topographic master code it would have been necessary to refer to page 13 in the nomenclature for the specific code numbers for elbow joint and wrist joint. The two operations listed above would have been grouped on one operation index card as shown in Chart 3 below.

If one of the entries given in the examples dealing with disease diagnoses had shown that an operation had been performed, the complete code number for the operation would have been recorded in the appropriate column on the disease card.

DUAL GROUPING

Grouping diseases simultaneously by topography and etiology and operations simultaneously by topography and procedure calls for a specially designed disease and operation card. This system is newer than the system just described, but experience has shown that it can be learned easily and used effectively by persons having little training in the use of the nomenclature. While it is recommended primarily for nonteaching hospitals it has been used effectively by several of the large teaching hospitals.

When this system of grouping is employed, the following topographic numbers are used as titles for the disease and operation cards. Complete topographic numbers and complete etiologic code numbers are recorded in the appropriate columns on the card:

00.—Diseases and conditions of Psychobiologic Unit
01.—Diseases and conditions of Body as a Whole
02.—Diseases and conditions of Head and Face
03.—Diseases and conditions of Neck, Thorax, Wall, and Mediastinum
04.—Diseases and conditions of Abdomen, Abdominal Wall and Pelvis
05.—Diseases and conditions of Other Areas of Trunk
06.—Diseases and conditions of Peritoneum and Serous Sacs
07.—Diseases and conditions of Superficial Fossae
08.—Diseases and conditions of Upper Extremity
09.—Diseases and conditions of Lower Extremity
10.—Diseases and conditions of Combined Sites
11.—Diseases and conditions of Skin Proper
12.—Diseases and conditions of Superficial Mucous Membrane
(13.—, 14.—Diseases and conditions of Regions of Skin)
15.—Diseases and conditions of Glands of Skin and Superficial Mucous Membranes
16.—Diseases and conditions of Hair

(Continued on page 66)

OPERATION INDEX	CODE NO. 24.—80	TITLE Manipulation of joint (Specify joint)			
Hosp. No.	Sex	Age	Result	Site	Surgeon
7841	14	M	I	243	White
9991	24	F	I	244	Smith

chart 3

DISEASE INDEX	CODE NO. 190—32.	DIAGNOSIS Chemical burn of breast (Specify poison)					
Hosp. No.	Sex	Age	Result	Site	Etiology	Operation	Physician
1641	F	28	I		3218		Brown
2987	M	39	I		322		Black

chart 2

new

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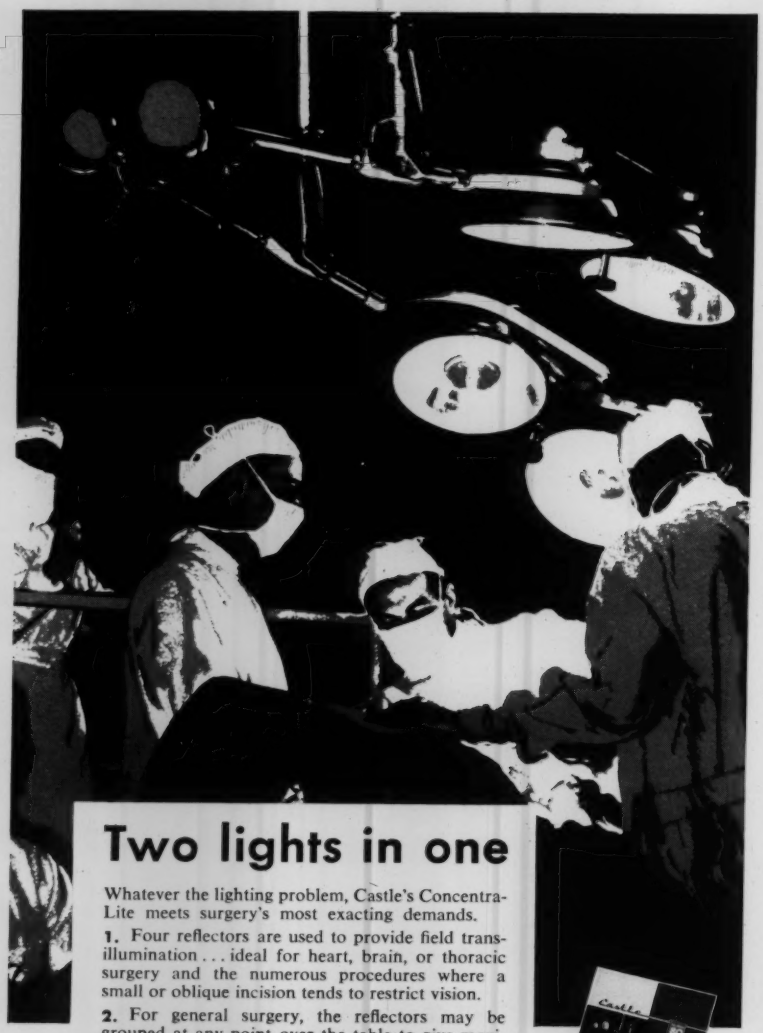
19.—Diseases and conditions of Breast
20.—Diseases and conditions of Bones Generally, and Special Structures
21.—Diseases and conditions of Bones of Cranium, Face and Neck (exclusive of Vertebrae)
22.—Diseases and conditions of Bones of Spine and Trunk
23.—Diseases and conditions of Bones of Extremities
24.—Diseases and conditions of Joints
25.—Diseases and conditions of Cartilages and Bursas
26.—Diseases and conditions of Ligaments
27.—Diseases and conditions of Muscles
28.—Diseases and conditions of Tendons and Tendons Sheaths
29.—Diseases and conditions of Fasciae
2x.—Diseases and conditions of Bones in Combination
30.—Diseases and conditions of Respiratory System
31.—Diseases and conditions of Nose
32.—Diseases and conditions of Accessory Sinuses
33.—Diseases and conditions of Larynx
34.—Diseases and conditions of Trachea
35.—Diseases and conditions of Bronchi and Bronchioles
36.—Diseases and conditions of Lungs
37.—Diseases and conditions of Pleura
40.—Diseases and conditions of Cardiovascular System (generally combined)
41.—Diseases and conditions of Heart
42.—Diseases and conditions of Pericardium
43.—Diseases and conditions of Myocardium
44.—Diseases and conditions of Conduction System
45.—Diseases and conditions of Endocardium, Vales and Chordae Tendineae
46.—, 47.—Diseases and conditions of Arteries
48.—Diseases and conditions of Veins
49.—Diseases and conditions of Capillaries
50.—Diseases and conditions of Blood and Blood Forming Organs
51.—Diseases and conditions of Plasma Constituents
52.—Diseases and conditions of Spleen (fixed cells)
53.—Diseases and conditions of Marrow
54.—Diseases and conditions of Lymphatic Channels and Lymph
55.—Diseases and conditions of Lymph Nodes (fixed cells)
60.—Diseases and conditions of Digestive System (generally combined)
61.—Diseases and conditions of Mouth
62.—Diseases and conditions of Salivary Glands
63.—Diseases and conditions of Pharynx and Esophagus
64.—Diseases and conditions of Stomach
65.—Diseases and conditions of Small Intestine and Mesentery
66.—Diseases and conditions of Large Intestine: Appendix
67.—Diseases and conditions of Anus
68.—Diseases and conditions of Biliary Tract
69.—Diseases and conditions of Pancreas
70.—Diseases and conditions of Urogenital System (generally combined)
71.—Diseases and conditions of Kidney
72.—Diseases and conditions of Renal Pelvis and Ureter
73.—Diseases and conditions of Bladder
74.—Diseases and conditions of Urethra
75.—Diseases and conditions of External Male Organs
76.—Diseases and conditions of Internal Male Organs
77.—Diseases and conditions of External Female Organs
78.—Diseases and conditions of Internal Female Organs
79.—Diseases and conditions of Fetal Structures
7x.—Diseases and conditions of Female Genital Organs during pregnancy, Parturition and the Puerperium
80.—Diseases and conditions of Endocrine Glands
81.—Diseases and conditions of Thyroid Gland
82.—Diseases and conditions of Parathyroid Glands
83.—Diseases and conditions of Thymus Gland
84.—Diseases and conditions of Pituitary Gland
85.—Diseases and conditions of Pineal Gland
86.—Diseases and conditions of Adrenal Glands
87.—Diseases and conditions of Pancreas
88.—Diseases and conditions of Gonads
89.—Diseases and conditions of Carotid Gland
90.—Diseases and conditions of Nervous System, generally
91.—Diseases and conditions of Meninges

(Continued on page 67)



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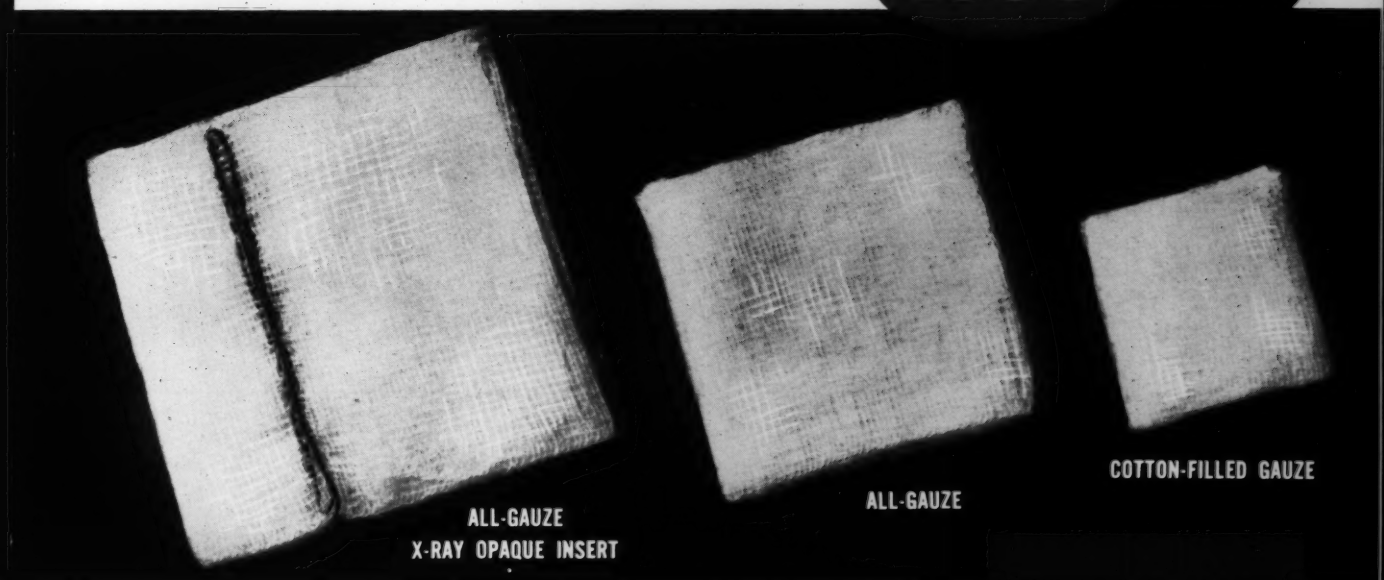

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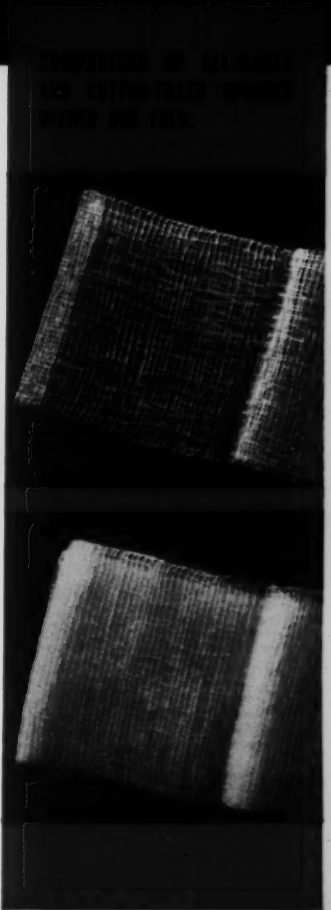

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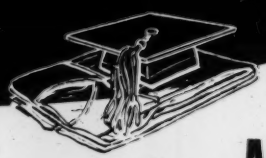

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93.—, 94.—, 95.—, Diseases and conditions of Brain
96.—Diseases and conditions of Cranial Nerves
97.—Diseases and conditions of Spinal Cord
98.—Diseases and conditions of Peripheral Nerves and Plexuses
99.—Diseases and conditions of Vegetative Nervous System: Sympathetic and Parasympathetic (autonomic) including mixed Ganglia
x0.—Diseases and conditions of Organs of Special Sense
x1.—, x2.—, x3.—, x4.—, Diseases and conditions of Structures concerned with Vision
x5.—, x6.—x Diseases and conditions of Structures Auxiliary to the Eyes
x7.—, and x8.—Diseases and conditions of Acoustic Sense
x9.—Diseases and conditions of Vestibular Equilibratory Sense

USE DETERMINES TITLE

When these numbers are used in the Operation Index the title would be changed from *Diseases and Conditions of* to *Operation on.* The number of cards in the Operation Index will be less than that encountered in the Disease Index, inasmuch as operations are not performed on all organs and parts of the body. A review of the topographical section of the nomenclature (pages 3-46) will show that these two-digit code numbers have been taken directly from the nomenclature itself and are the correct numbers for organs or anatomical parts. It is recommended that a decimal and a hyphen be used following the two-digit numbers to show that a system of grouping is being used. As is true in all indexing, a disease or operation index card should be made up only when the indexer encounters a diagnosis or operation necessitating such a card.

The use of this system greatly diminishes the number of cards in the index. It also decreases the amount of time required to index and the possibility of error in recording information in the index because only diseases whose assigned code number in the nomenclature starts with the two digit topographic number listed on a card in the Disease Index could be entered on that specific card. In other words, the disease "calculus of the bladder" bearing the code number 730-615 could be entered only on the card entitled "73.- Diseases and conditions of the Bladder." The complete code number 730 is entered in the appropriate column on the card and the complete code number -615 is entered in column 6 of the etiologic categories. In the event it was inadvertently entered on the card bearing the number 74.- it would immediately be brought to the attention of the indexer when he entered the complete code number 730 in the site column on the card. All other numbers on that card start with 74.

MAY NEED ONLY PROCEDURE NUMBER

If an operation bearing the same topographic code number as the disease number is listed on the medical record, it is not necessary to repeat the topographic number. It is necessary to enter only the procedure number for the operation in the appropriate site. If an operation procedure having a different topographic code number is performed, the complete number should be entered in the column headed "Operation". Both operations would likewise be recorded in the Operation Index. For example:

Diagnosis Appearing on Medical Records	*Code Number*
1. Abscess of kidney due to staphylococcus Drainage of kidney.... (Case No. 691—Male, age 41. Result: Improved Dr. Green	710-100.2 710-02
2. Pyelonephritis ..... (Case No. 763 — Female, age 27. Result: Improved Dr. Jones	719-100
3. Fistula of kidney due to trauma	710-400.3

(Continued on next page)

DISEASE INDEX | CODE NO. 71.— | DIAGNOSIS Diseases and conditions of kidney

Hosp. No.	Age	Sex	Result	Site	Etiologic Categories											Operation	Physician
					0	1	2	3	4	5	55	6	7	8	9	x or y	
691	41	M	I	710		100.2											—02	Green
763	27	F	I	719		100												Jones
879	10	F	I	710					400.3									Williams
965	46	M	I	719								615					—03	Jack
1071	49	F	I	710										8091			—12	Spooner

chart 4

OPERATION INDEX | CODE NO. 71.— | TITLE Operations on kidney

Hosp. No.	Age	Sex	Result	Site	Operative Procedures									Surgeon
					0	1	2	3	4	5	6	7	8	
691	41	M	I	710	02									Green
965	46	M	I	719	03									Jack
1071	49	F	I	710		12								Spooner

chart 5

(Case No. 879 — Female, age 10. Result: Improved
Dr. Williams

4. Calculus in kidney.....719-615
   Nephrolithotomy 719-03
   (Case No. 965—Male, age 46. Result: Improved
   Dr. Jack
5. Adenocarcinoma of kidney 710-8091
   Nephrectomy, complete 710-12
   (Case No. 1071—Female, age 49. Result: Improved
   Dr. Spooner

The diagnoses and operations listed above would have been grouped on the disease and operation index cards as shown in Charts 4 and 5 on page 67.

Experience has proved that effective indexing of diseases and operations may be accomplished through the use of one of the grouping systems described on the previous pages. Whenever a system of grouping is used, it is imperative that an exact description of the extensiveness of the system be included in the procedure manual of the medical record department. The future value of the index will depend to a great extent upon these written procedures, since they will enable persons interested in locating material in the index to understand the manner in which the information has been entered. ■

BIBLIOGRAPHY

1. Huffman, Edna K. *Manual for Medical Record Librarians* (4th ed.), Physicians' Record Company, Chicago, 1955.
2. *Standard Nomenclature of Disease and Operations* (4th ed.) The Blakiston Company, Chicago, 1952.

Notes and Comment

Needed: more registered medical record librarians

The table (right), prepared by the American Association of Medical Record Librarians, provides the most recent and accurate information available as to personnel needs in this field. Hospitals listed by the American Hospital Association are grouped by size within each state. The table shows that additional registered personnel are needed in all hospitals, but particularly in those with fewer than 100 beds. Even if an average of four of these hospitals now without a registered record librarian were to share the services of one registered person, almost 1000 additional librarians would be needed now. The number of new graduates from all approved schools for medical record librarians in the United States is still under 200 per year. ■

REGISTERED MEDICAL RECORD LIBRARIANS EMPLOYED IN U. S. HOSPITALS

STATE	NO. OF HOSP. IN STATE	NO. HAVING RRL	NUMBER OF HOSPITALS EMPLOYING RRL ACCORDING TO BED CAPACITY							NO. OF RRL IN STATE
			Under 25	25 to 49	50 to 99	100 to 199	200 to 299	300 to 499	Over 500	
Alabama	126	20	0	0	4	6	5	4	1	27
Arizona	71	10	0	1	0	3	1	4	1	14
Arkansas	86	16	0	1	6	5	0	2	2	22
California	424	134	0	7	23	28	26	24	26	195
Colorado	101	21	0	1	5	5	7	2	1	33
Connecticut	72	25	0	1	2	6	5	7	4	35
Delaware	16	5	0	0	0	3	1	1	0	5
Dist. of Columbia	28	13	0	0	1	2	4	4	2	28
Florida	154	32	0	1	6	10	9	4	2	44
Georgia	151	24	0	1	2	11	3	5	2	33
Idaho	52	2	0	0	1	1	0	0	0	2
Illinois	357	106	0	1	10	47	21	13	14	142
Indiana	142	31	0	0	4	7	13	4	3	38
Iowa	128	21	0	2	0	12	3	3	1	21
Kansas	155	33	0	4	11	13	1	2	2	40
Kentucky	127	19	0	0	1	7	3	7	1	24
Louisiana	132	23	0	0	1	6	9	5	2	30
Maine	56	7	0	0	3	2	2	0	0	7
Maryland	84	20	0	0	1	6	4	5	0	32
Massachusetts	211	66	0	4	9	25	13	10	5	87
Michigan	263	61	0	4	9	17	14	9	8	82
Minnesota	210	38	0	2	7	15	6	4	4	52
Mississippi	108	7	0	1	2	2	0	2	0	8
Missouri	156	39	0	0	3	13	8	9	6	59
Montana	63	11	0	1	2	5	3	0	0	11
Nebraska	114	21	1	0	4	11	3	1	1	26
Nevada	17	3	0	0	1	1	1	0	0	4
New Hampshire	41	8	0	0	2	5	1	0	0	8
New Jersey	159	49	0	2	4	11	15	11	6	63
New Mexico	54	10	0	0	6	3	1	0	0	12
New York	497	145	0	2	18	45	3	28	21	189
North Carolina	181	24	1	0	3	7	5	5	3	36
North Dakota	52	10	0	0	5	4	1	0	0	11
Ohio	260	76	1	1	8	20	22	17	7	92
Oklahoma	126	16	1	0	6	4	2	3	0	22
Oregon	80	13	0	1	3	3	2	3	1	16
Pennsylvania	346	114	2	2	7	42	24	23	14	146
Rhode Island	23	9	0	0	0	5	1	2	1	10
South Carolina	77	10	0	0	2	5	1	1	1	12
South Dakota	67	13	1	1	3	5	3	0	0	14
Tennessee	153	18	0	1	2	4	6	3	2	25
Texas	559	72	2	10	12	20	13	7	8	100
Utah	39	7	0	0	1	2	2	1	1	9
Vermont	28	7	0	0	4	1	2	0	0	8
Virginia	125	18	0	1	2	6	5	2	2	23
Washington	139	33	0	1	4	12	6	8	2	44
West Virginia	90	16	0	0	3	7	5	1	0	18
Wisconsin	221	61	0	3	14	20	16	4	4	71
Wyoming	35	4	0	0	1	2	1	0	0	4
GRAND TOTAL	6,956	1,541	9	57	229	502	330	249	165	2,028
Total listed by AHA			985	1,628	1,559	1,278	555	414	537	
Per cent of listed hospitals with RRL	100.0	22.1	.9	3.5	14.6	39.2	59.4	60.1	30.7	

purchasing

machines are the drudges in this inventory control system

by JOSEPH A. GERAGHTY

Mechanical aids are of paramount importance in the inventory control system at Mary Immaculate Hospital, Jamaica, N. Y., described in the following article, last of a series of three articles on inventory control. The system outlined here is in direct contrast to the one described in the second article in the series, which emphasized visual controls and manual record keeping.

THE TITLE OF this article does not suggest that a machine will substitute for a supervisor with intelligence and judgment. However, we have found that a mechanized setup that frees a supervisor from the details of pen-and-pencil systems and routines is the first step toward a strong inventory control system.

Under the old inventory system at Mary Immaculate Hospital, considerable time was invested in record keeping in the accounting department and storeroom, but no results were forthcoming. We used perpetual inventory forms and did all our posting by hand. The most unfortunate result of this method, as one of our inventory clerks observed, was that we invariably had too much of the wrong item, and an insufficient amount of the particular item requisitioned.

Another serious disadvantage of the old system was that we were dependent on one individual in the storeroom. Since we used a handwritten requisition, the storekeeper often knew from experience what was ordered; if he didn't, he sent what he thought was wanted. This created a difficult situation for the three persons who were concerned with requisitions: (1) the nurse or department supervisor who requisitioned the items; (2) the stock clerk who handled the order; and (3) the bookkeeper who posted the records. The pen-and-ink system was in itself a primary reason for "runouts" in some items and overstocked supplies in others.

An additional problem was a shortage of storage space due to the overstocking. This resulted in supplies being stored in aisles or any space available at the time of delivery. This arrangement made an accurate physical count impossible, not to mention the man hours lost in unnecessary motion.

The system was difficult, if not impossible to audit accurately. The hospital was vulnerable to losses from excessive waste and shrinkage as well as to losses from fraud and pilferage.

Obviously, the hospital needed to reorganize its inventory control methods.

REORGANIZATION PLANS

The first step in the complete overhaul of the system was reorganizing the physical layout of the bins in the storeroom. Items were grouped systematically, and the height of the bins was reduced so that a person of average height could reach and see the items on the top shelf. This reorganization prevents supplies from becoming forgotten or ignored, and also fa-

Joseph A. Geraghty is comptroller of Mary Immaculate Hospital, Jamaica, N.Y.

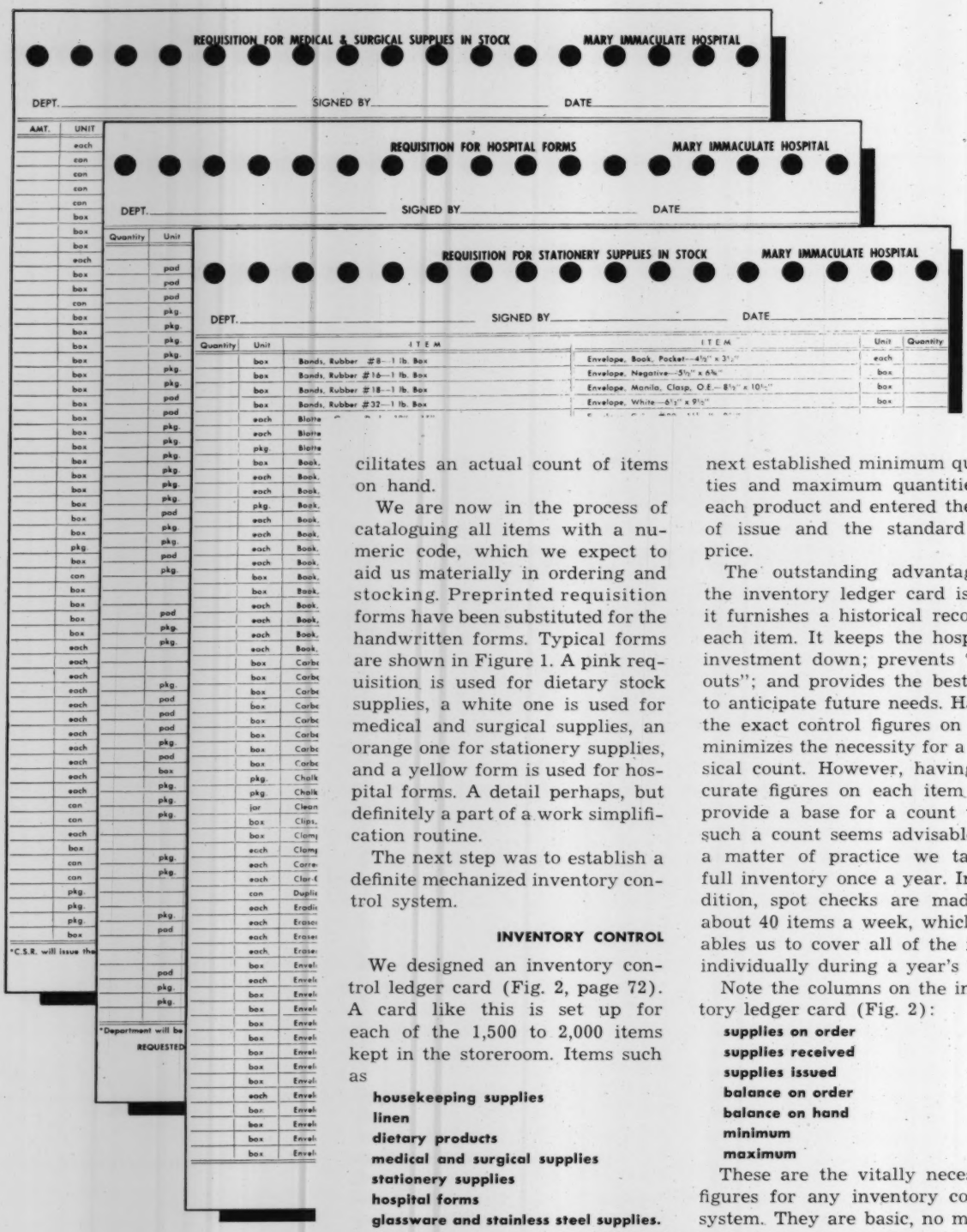

Fig. 1

cilitates an actual count of items on hand.

We are now in the process of cataloguing all items with a numeric code, which we expect to aid us materially in ordering and stocking. Preprinted requisition forms have been substituted for the handwritten forms. Typical forms are shown in Figure 1. A pink requisition is used for dietary stock supplies, a white one is used for medical and surgical supplies, an orange one for stationery supplies, and a yellow form is used for hospital forms. A detail perhaps, but definitely a part of a work simplification routine.

The next step was to establish a definite mechanized inventory control system.

INVENTORY CONTROL

We designed an inventory control ledger card (Fig. 2, page 72). A card like this is set up for each of the 1,500 to 2,000 items kept in the storeroom. Items such as

housekeeping supplies
linen
dietary products
medical and surgical supplies
stationery supplies
hospital forms
glassware and stainless steel supplies.

Although we are considering taking over storage of maintenance supplies, drugs will not be included. Drugs are kept in a separate storeroom in the hospital pharmacy.

In setting up the original ledger cards, we took an actual count of the items on hand and tabulated those items that were in order. We next established minimum quantities and maximum quantities for each product and entered the unit of issue and the standard unit price.

The outstanding advantage of the inventory ledger card is that it furnishes a historical record of each item. It keeps the hospital's investment down; prevents "run-outs"; and provides the best way to anticipate future needs. Having the exact control figures on hand minimizes the necessity for a physical count. However, having accurate figures on each item does provide a base for a count when such a count seems advisable. As a matter of practice we take a full inventory once a year. In addition, spot checks are made on about 40 items a week, which enables us to cover all of the items individually during a year's time.

Note the columns on the inventory ledger card (Fig. 2):

supplies on order
supplies received
supplies issued
balance on order
balance on hand
minimum
maximum

These are the vitally necessary figures for any inventory control system. They are basic, no matter how large or small a hospital might be. Yet, it is a staggering task to keep records on 2,000 items when a hand posting system is used, and it is virtually impossible to keep them accurately. That is the job we have turned over to a machine.

Daily posting is always made

THE ACCOUNTING PROCEDURE of this modern hospital was greatly simplified by a National System.

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A NATIONAL ACCOUNTING MACHINE posts all records quickly and accurately.

"Our *National* System pays for itself every 2 years... returns 50% annually on our equipment investment!"

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"Our National 'Class 31' accounting machine reduces the time needed to complete the three most important phases of our accounting work: (1) patients' accounts receivable, (2) accounts payable and (3) payroll. It enables us to post records quickly and accurately. In fact, payroll alone is now finished in half the time. And, because it is so simple to operate, our National '31' makes it easier for us to train new employees.

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R. E. Pieratt *Administrator of the Central Michigan Community Hospital*

Your hospital, too, can profit from the time- and money-saving features of a National System. Nationals repay their original cost quickly, then return a regular yearly profit through savings they make for you. For complete information, call your nearby National representative. He's listed in the yellow pages of your phone book.

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in three runs. The three primary posting mediums are: (1) the copy of the purchase order that shows supplies were ordered; (2) the copy of the purchase order that shows supplies were received in the storeroom; and (3) the preprinted requisition form described previously.

The inventory control journal sheet shown in Figure 2 is inserted in the carriage of the accounting machine and the inventory ledger card is lined up on top. The operator picks up the balance and the inventory ledger card is lined up on top. The operator picks up the balance on order and the balance on hand and also a proof figure which is the total of the balance on hand and on order. If these figures are picked up correctly, the machine automatically prints ".00" in the column shown.

Reading from the purchase order (Fig. 3, p. 74), the operator posts the date and reference number and then posts the proper figure in the "Supplies on Order" column. The machine now moves forward automatically and posts a new "Balance on Order" figure. The "Balance on Hand" figure prints automatically, the minimum and maximum figures are entered, and a new proof prints.

When supplies are received in the storeroom, that information is noted on the storeroom's copy of the purchase order and it is forwarded to the bookkeeping department. It is then posted in similar fashion in the "Supplies Received" column of the proper inventory ledger card, and the machine automatically deducts the proper amount from the "Balance on Order" figure and adds the same amount to the "Balance on Hand" figure. The proof figure also prints automatically.

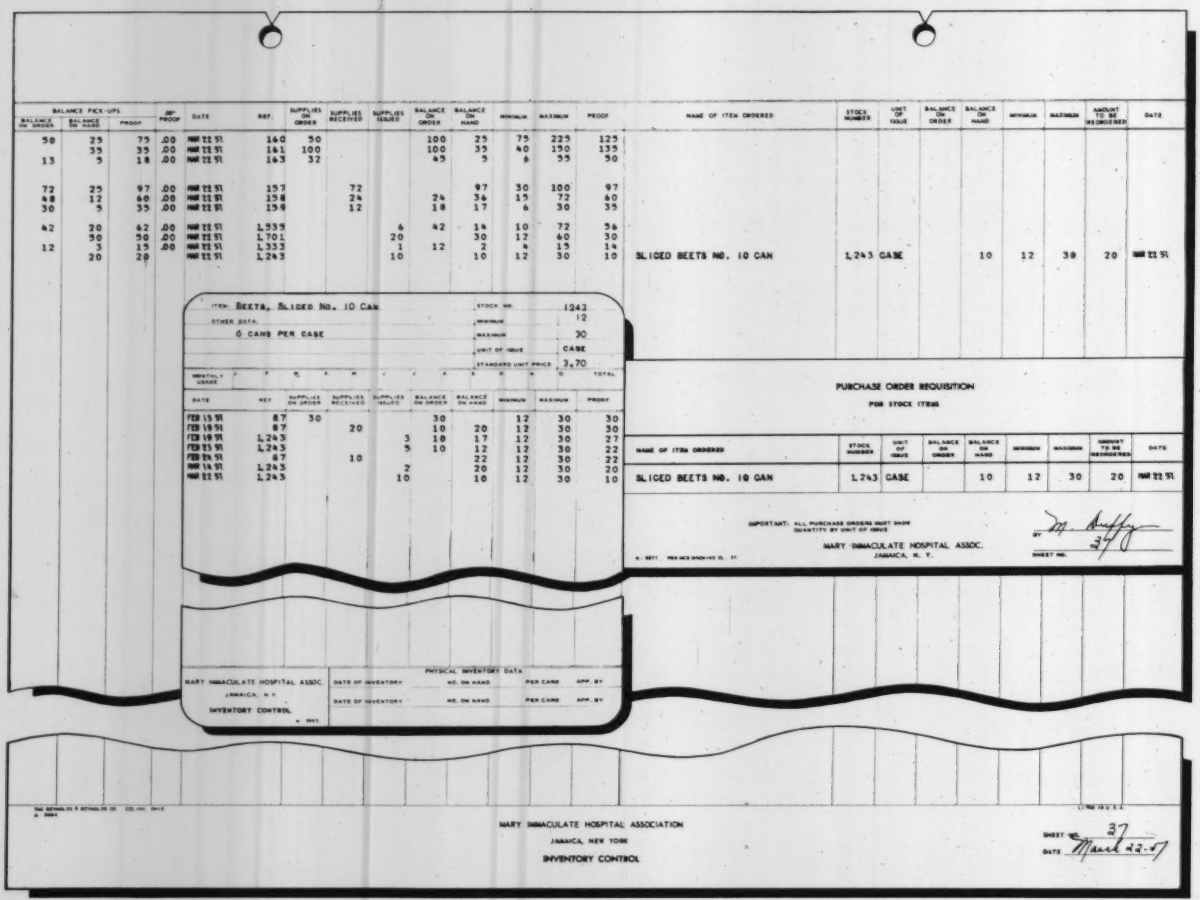
Before the daily requisitions are posted, the individual items are totaled on a pegboard so that only one daily issuance posting is made to the particular inventory ledger card. When the operator posts requisitions she follows the same routine. She picks up the old balances and the proof figure and the machine prints ".00".* Date and reference number are posted, and amount is posted in the "Supplies Issued" column. The amount is automatically deducted from the "Balance on Hand" figure, and the minimum and maximum figures are entered. When the proof figure prints, it is at this point the most important feature of machine posting is demonstrated.

REORDERING

If the amount issued brings the "Balance on Hand" and the "Balance on Order" figure down to below what we have determined to be the minimum quantity, the ma-

* As soon as our numeric coding system is completed, we plan to incorporate the code number of the item in the pick-ups. When the machine prints ".00" this will prove that the operator has posted to the proper ledger card. However, for those hospitals that do not use numeric coding, the system described here will suffice.

Fig. 2



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chine signals that fact automatically. The purchase order requisition (Fig. 2, p. 72) is then inserted in the carriage of the machine, and a description of the item to be ordered is typed in, along with the stock number and the unit of issue. The machine now automatically prints on the purchase order requisition the balances and the minimum and maximum figures, as well as *the total amount to be reordered.*

Completed purchase order requisitions are forwarded to the purchasing department. When the accounting copies of the purchase orders are received next day, they are checked against the journal to insure that all needed items have been properly ordered.

It is significant that no mental arithmetic or pencil and paper calculations enter into the production of these records. All computations are made automatically by machine. Moreover, it is not necessary for an operator to be watching for individual ledger cards that indicate a subminimum quantity on hand. The reordering feature is fully automatic and absolutely accurate.

DEPARTMENTAL EXPENSE COST

When the various inventory item issuances have been posted, the inventory clerk prices each item issued. The cost of these items is then charged to the departmental expense accounts.

The unit price of items carried in stock has been established on a standard unit cost system. The standard cost is the estimated cost to be paid during the year for any item purchased in the usual or normal quantity. A standard price has, therefore, been determined for each item and entered on top of the inventory ledger card. Upon receipt of an invoice, each item is priced at standard price on the invoice in addition to actual cost. The total standard price of the invoice is then computed and an entry made in the voucher register as follows.

Debit:
Stores control at standard price
Debit or Credit:
Price variance (expense or income)
Credit:
Accounts payable at cost

(Continued on next page)

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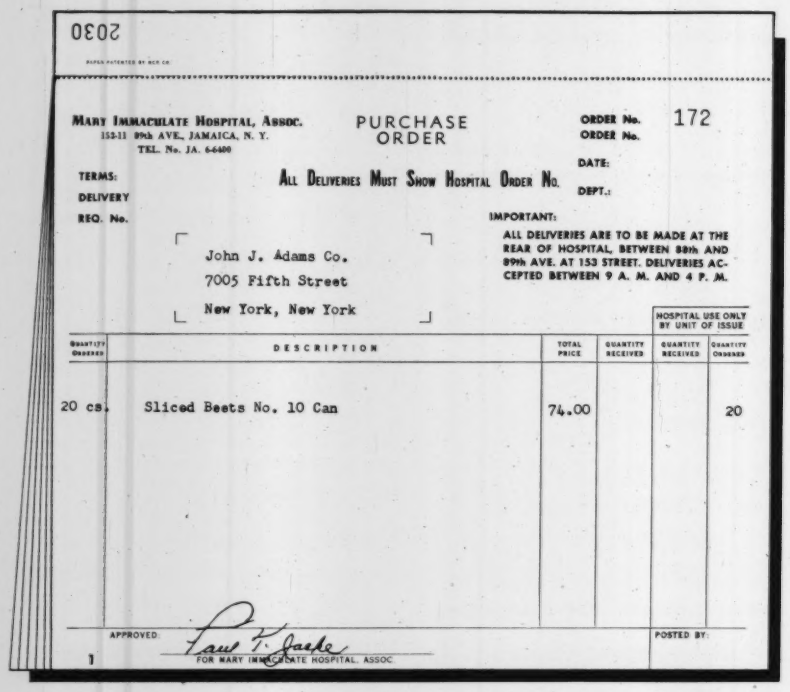


2030

MARY IMMACULATE HOSPITAL, ASSOC.
153-11 89th AVE., JAMAICA, N. Y.
TEL. No. JA. 6-6400

PURCHASE ORDER

ORDER No. 172
ORDER No.
DATE:
DEPT.:

TERMS:
DELIVERY
REQ. No.

ALL DELIVERIES MUST SHOW HOSPITAL ORDER NO.

IMPORTANT:
ALL DELIVERIES ARE TO BE MADE AT THE REAR OF HOSPITAL, BETWEEN 88th AND 89th AVE. AT 153 STREET. DELIVERIES ACCEPTED BETWEEN 9 A. M. AND 4 P. M.

John J. Adams Co.
7005 Fifth Street
New York, New York

QUANTITY ORDERED	DESCRIPTION	TOTAL PRICE	QUANTITY RECEIVED	HOSPITAL USE ONLY BY UNIT OF ISSUE: QUANTITY RECEIVED	HOSPITAL USE ONLY BY UNIT OF ISSUE: QUANTITY ORDERED
20 cs.	Sliced Beets No. 10 Can	74.00			20

APPROVED: Paul T. Jacobs
FOR MARY IMMACULATE HOSPITAL, ASSOC.
POSTED BY:
1

Fig. 3

How does the system facilitate determination of departmental costs?

The use of a standard unit price offers important advantages. Here are a few:

1. The need to compute the unit price of an item each time a purchase is received is eliminated. A standard price remains constant throughout the year and is the price used for extending requisitions.

2. Comparison of standard cost with actual cost will indicate such inefficient purchasing practices as the following:

(a) Purchasing from unfavorably located suppliers, thereby increasing transportation costs;

(b) purchasing in nonstandard lots; and

(c) purchasing from suppliers other than those offering the most favorable terms.

3. The system will enable us to show hospital personnel the cost of the item requested by preprinting unit prices on stores requisitions. This we plan to do in the near future.

WHAT ARE THE RESULTS?

1. The mechanized and automatic reordering of supplies that fall below the minimum has eliminated the keeping of inventory records by the storekeeper. Human fallibility has been eliminated in reordering items that reach the minimum quantity.

2. The preprinted requisitions have reduced departmental requisitions by half. They have also reduced to a minimum incorrect ordering and issuing of supplies.

3. The standard unit cost has eliminated the calculating of cost each time an item is issued. An analysis of the variance account will disclose inefficient purchasing practices.

4. The reorganizing of the stockroom and inventory control has reduced storeroom personnel from five employees to two. It has reduced to a minimum losses due to excessive waste, fraud and pilferage.

5. We now have controls on inventory that did not exist in the past. Through these controls, the cost of maintaining a central storeroom and inventory system has been lowered, making possible a significant saving for the hospital.

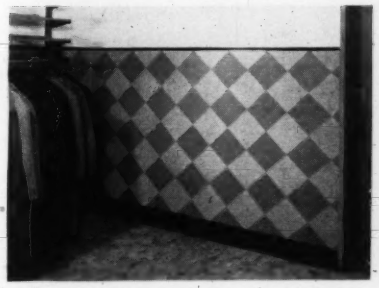
6. We obtained adequate storage space with the proper inventory controls because we are able to maintain a low inventory. ■

equipment and supply review

An endeavor is made to screen carefully the products appearing in this section. However, the statements printed have been made by the manufacturer and are brought to your attention primarily to keep you informed of new developments in the field. —The Editors.

Plastic wall covering (13B-1)

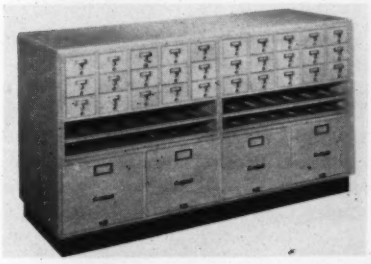
Manufacturer's description: This new fire-resistant, vinyl plastic wall covering possesses the soil resistance and easy maintenance characteristics demanded for hospital and clinic



installations. The new wall tile has a high degree of resistance to soiling, staining, fading, scuffing and the effects of moisture. It is listed under the label service of Underwriters' Laboratories, Inc. Currently made in a 9 by 9-in. size, it is available in a softly textured design in nine colors. *Armstrong Cork Co., Dept. H, Lancaster, Pa.*

File and atlas case (13B-2)

Manufacturer's description: In large libraries, this combination file and atlas case is claimed to supplement standard separate pieces, and should be ideal in smaller libraries as a space-saving substitute for larger equipment. The case features warp- and check-free construction, dovetailed joints, hand-rubbed finishes, bronze hardware, mortise-and-tenon joining and protective hardwood nosing. The unit measures 39 by 68 by 25 in. and provides 30 file card drawers, atlas space, and four standard file drawers. *Standard Wood Products Corp., Library Div., Dept. H, 10 Columbus Circle, New York 19, N.Y.*

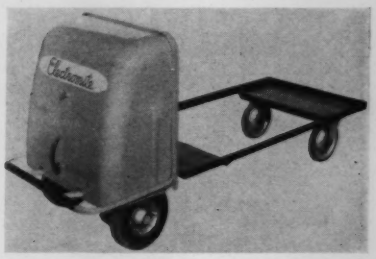


Nonslip bottle (13B-3)

Manufacturer's description: A new intravenous solution bottle incorporates nonslip thumb and finger grips and a unique label with numerals printed in a "working" position cross-calibrated with bottle numerals. Bottles in the pediatric series have 10 c. c. graduations. *Baxter Laboratories, Inc., Dept H, Morton Grove, Ill.*

Motorized carrier (13B-4)

Manufacturer's description: This new electric unit can power any type of wheeled cart or truck that is now manually operated. Teamed with hand trucks, it provides a safe, motorized carrier for a variety of items requiring transportation in hospitals and other institutions. The unit is noiseless, free from gas fumes, and poses no fire hazard. Speed is adjusted to an average walk. Forward and reverse is controlled by a hand grip which attaches to the cart or truck



▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 18 E. Division St., Chicago 10, Ill.

PRODUCT NEWS

_____Plastic wall covering (13B-1)
_____File and atlas case (13B-2)
_____Nonslip bottle (13B-3)
_____Motorized carrier (13B-4)
_____Solid-top portable stand (13B-5)
_____Packaged hot water system (13B-6)
_____New filing cabinets (13B-7)
_____Versatile office machine (13B-8)
_____Special radiator (13B-9)
_____Perforated pan (13B-10)
_____Laminated wall tile (13B-11)
_____'Low-design' floor machine (13B-12)
_____Space divider with planter (13B-13)
_____Data punch (13B-14)

PRODUCT LITERATURE

_____Felt tip pens (13BL-1)
_____Sales catalogue (13BL-2)
_____Monitoring systems (13BL-3)
_____Horizontal unit heaters (13BL-4)
_____Radiological motion picture recording (13BL-5)
_____Photomicrographs (13BL-6)
_____Corrosion preventing (13BL-7)

NAME and TITLE _____

HOSPITAL _____

ADDRESS _____

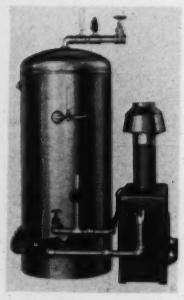
(Please type or print in pencil)

handle. Based on continuous use on level floors, it travels approximately 10 miles per battery charge. *The Borne Co., Inc., Dept. H, 1547 Kellogg St., Covington, Ky.*

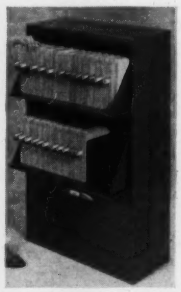
Solid-top portable stand (13B-5)
Manufacturer's description: To meet the need for portable stands for equipment other than the standard business machines, this solid steel topped stand has been designed. By adding one or two drop leaves, additional work space is provided

in existing floor space. Equipped with 2-in. rubber swivel casters, the stand is available in five colors. The standard height is 26½ in., but it can be obtained in a 35½-in. height for stand-up work. *Tiffany Stand Co., Dept. H, 7350 Forsyth, St. Louis 5, Mo.*

Packaged hot water system (13B-6)
Manufacturer's description: This hot water system is designed specifically to fulfill general hospital needs, and it can deliver almost its entire storage capacity with no drop in outlet temperature. The unit maintains two sections of hot water supply within the same tank. Maximum efficiency with appreciable gas saving is the result of this AGA and ASME approved system. All equipment carries a full five-year guarantee. *Laars-Engineers, Dept. H, 13246 Saticoy St., North Hollywood, Calif.*



New filing cabinets (13B-7)
Manufacturer's description: This redesigned line of filing cabinets is completely different from general filing equipment in appearance, operation, and use. It replaces the conventional file drawer with a rocking compartment, and introduces side-system filing. Operating on a patented suspension, the compartment swings down, exposing its entire contents on an open-faced shelf. The increased visibility and accessibility of this opening speeds filing and finding and provides quicker reference. Removing or replacing folders requires only a simple sliding action. The files are made in legal and letter sizes. *Yawman and Erbe Mfg. Co., Dept. H, Rochester 3, N.Y.*



Versatile office machine (13B-8)
Manufacturer's description: A versatile new office machine combining an 84-character, full-keyboard electric typewriter with a high-speed,

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modern hospitals use

Gendron **recovery room wheel stretchers**

Easy to handle . . . protects the patient!

Gendron's Model 868, recovery room wheel stretcher is specially designed to fulfill the necessary requirements of *all* hospital recovery rooms . . . *EFFICIENTLY AND AT LOW COST!* The Gendron 868 comes with many extras as STANDARD EQUIPMENT . . . with a complete line of accessories to accomplish specific recovery room functions.

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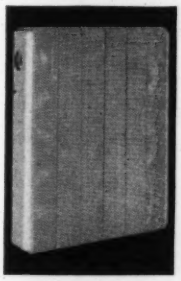
Model 868, Also Available With Stainless Steel Finish.

Gendron Wheel Company
PERRYSBURG, OHIO

accumulating register accounting machine is now available. There

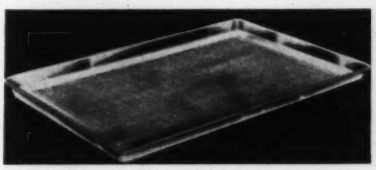
are ten models of the new machine, designed to meet increasing demands for flexibility in posting, accounting, and other areas. *Burroughs Corporation, Dept. H, 2nd at Burroughs St., Detroit 32, Mich.*

Special radiator (13B-9)
Manufacturer's description: A standard line of steam and hot water radi-



ators, specifically designed for use in mental and corrective institutions, features a box-type housing of heavy, closely perforated steel which completely covers the interior construction. Tampering and insertion of foreign matter is thus prevented, and thorough cleaning is accomplished simply by hosing down. Structural design keeps exposed surfaces of the radiator at temperatures safe to the touch. *Shaw-Perkins Mfg. Co., Dept. H, 201 E. Carson St., Pittsburgh 19, Pa.*

Perforated pan (13B-10)
Manufacturer's description: This perforated pan, made in aluminum or



stainless steel, can be used for many purposes as a single pan, or in conjunction with a solid pan. As a refrigerator pan and as a storage pan, it eliminates condensation by allowing air circulation. When used in combination with a solid pan, it is unsurpassed as a powder pan. It is useful for french fries, as a bacon fryer, noodle drier, glass drainer and for chicken storage. *Nash Metalware Co., Inc., Dept. H, 127 W. 17th St., New York, N.Y.*

Laminated wall tile (13B-11)
Manufacturer's description: This new melamine laminated wall tile resembles glass or marble in appear-

ance and is cigarette-proof, withstands boiling water, and resists heat to 275° F. Panels are scratch-resistant and are not stained by

An invisible vapor-spray that provides the answer to Hospital Management's search for an effective, safe and unobtrusive medium for quickly dispelling embarrassing Hospital odors.

***OZIUM QUICKLY REMOVES SMOKE...**
DESTROYS ODORS... AND REDUCES AIRBORNE BACTERIA
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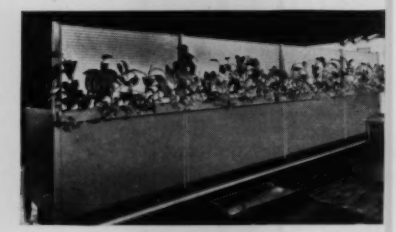
household solutions. They can be applied with special cement to any smooth, clean surface, including plaster, concrete, and plywood. These tiles never need polishing, painting, or resurfacing and will last indefinitely. They are available in marble finishes and in solid colors. *Reiss Associates, Inc., Plastics Division, Dept. H, Reiss Ave., Lowell, Mass.*

'Low-design' floor machine (13B-12)

Manufacturer's description: A single-brush machine measuring only 9½ in. in height permits its use in previously inaccessible areas when scrubbing, polishing, steel wooling, sanding, or grinding floors. Features include a new low-design motor; pistol-grip handles, designed to lessen hand fatigue and to start the motor under ordinary fingertip pressure; and retractable, individually suspended wheels to guarantee easy portability. A switch reverses the direction of rotation to greatly retard brush wear. The new machine is available in 17-in. and 21-in. brush sizes. *Hillyard Chemical Co., Dept. H, St. Joseph, Mich.*

Space divider with planter (13B-13)

Manufacturer's description: This "planter" or flower box attaches directly to the finishing posts of this company's line of free-standing space dividers. It finds particular importance in the reception rooms of institutions. The planter comes in several different sizes for a quick fit. *Marnay Sales Division, Rockaway Metal Products Corp., Dept. H, 1270 Broadway, New York 1, N.Y.*



Data punch (13B-14)

Manufacturer's description: New machine punches "Keysort" cards and imprints data on the card face in a simultaneous action. Principal use in hospital procedures is at nursing stations for the processing of requisition charge tickets. The data punch imprints such information as nursing station identification, patient's name, class of payment and other pertinent facts. At the same time the data is punched into the card. Light metal punch plates give precise control to punching and imprinting. Compact and nonelectrical, the machine can be located at points of greatest use. *Royal McBee Corp., Dept. H, Westchester Ave., Portchester, N.Y.*

product literature

(SEE COUPON, PAGE 75)

Felt tip pens (13BL-1)—This eight-page folder shows the many uses of these felt tip marking pens. It explains in detail three models, six interchangeable felt tip shapes, and transparent and opaque inks and cleanser. *Cushman & Denison Mfg. Co., Inc., Dept. H, 625 8th Ave., New York 18, N.Y.*

Sales catalogue (13BL-2)—The W. S. Merrell Company is distributing its new revised 1957 sales catalogue to hospitals and the drug trade. New features of the catalogue include alphabetical product arrangement, new format and easy-to-read bold type face. *The Wm. S. Merrell Co., Dept H, Lockland Station, Cincinnati 15, Ohio.*

Monitoring systems (13BL-3)—Complete monitoring systems for the detection, recording and warning of airborne particulate radioactivity are described in this new six-page bulletin, AM-57. The bulletin also describes monitoring system parts and assemblies available from the firm. *Nuclear Measurements Corp., Dept. H, 2460 N. Arlington Ave., Indianapolis 18, Ind.*

Horizontal unit heaters (13BL-4)—Performance data, complete wiring and piping diagrams, construction features and architects' specifications on this line of horizontal unit heaters are given in a newly issued catalogue. Additional information on available accessories is also furnished. *Young Radiator Co., Dept. H, Racine, Wis.*

Radiological motion picture recording (13BL-5)—This booklet discusses a new dynamic film method of recording fluoroscopic examination study. Various photographs demonstrate that the unit can be used for all diagnostic applications and does not interfere with normal fluoroscopic work habits. Ask for booklet XB-312-704. *Westinghouse Electric Corp., X-Ray Division, Dept. H, P.O. Box 416, Baltimore 3, Md.*

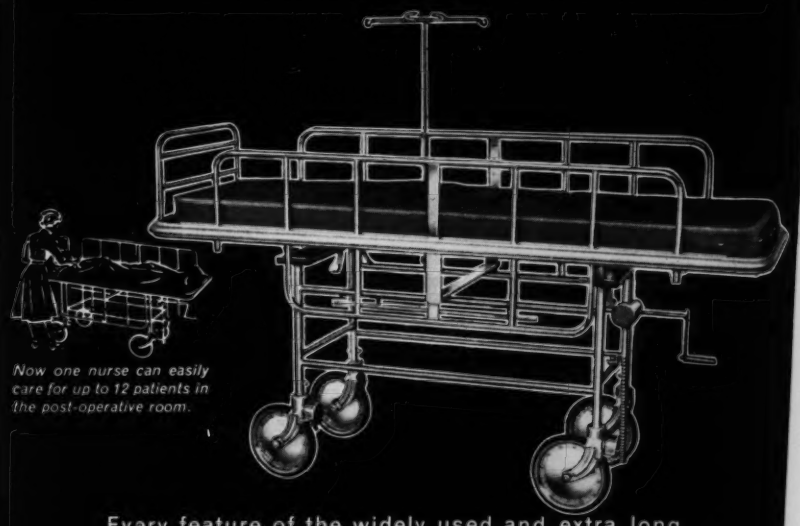
Photomicrographs (13BL-6) — This six-page pamphlet on photomicrography should interest those who produce color or black-and-white photographs of microscopic slides for use as records or to illustrate reports. Sections of the booklet deal with the mechanism of an adapter kit, optical considerations, microscope optics factors, and an explanation of illumination. *Eastman Kodak Co., Sales Service Division, Dept. H, Rochester 4, N.Y.*

Corrosion prevention (13BL-7)—In nontechnical language, this 16-page booklet explains how corrosion of stainless steel food processing and dairy equipment can be prevented. The booklet also tells how and why wrong bactericides are corrosive to stainless steel. *The Diversey Corp., Dept. H, 1820 W. Roscoe St., Chicago 13, Ill.*

MAXIMUM PATIENT COMFORT . . .
MAXIMUM ATTENDANT CONVENIENCE *with the*

Specially Engineered **COLSON**

Post Anesthesia Stretcher



Now one nurse can easily care for up to 12 patients in the post-operative room.

Every feature of the widely used and extra long COLSON PA Stretcher is designed for patient comfort, safety and to save nurses' time. The two guard rails may be easily raised or lowered. The litter is hinged at one end and its position is controlled by a single crank-operated elevating mechanism. Two special brake casters facilitate traveling down halls or render the stretcher immobile. Durably constructed for years of dependable service, the COLSON PA Stretcher is beautifully finished in stainless steel or gray enamel.

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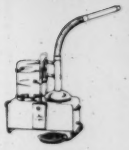

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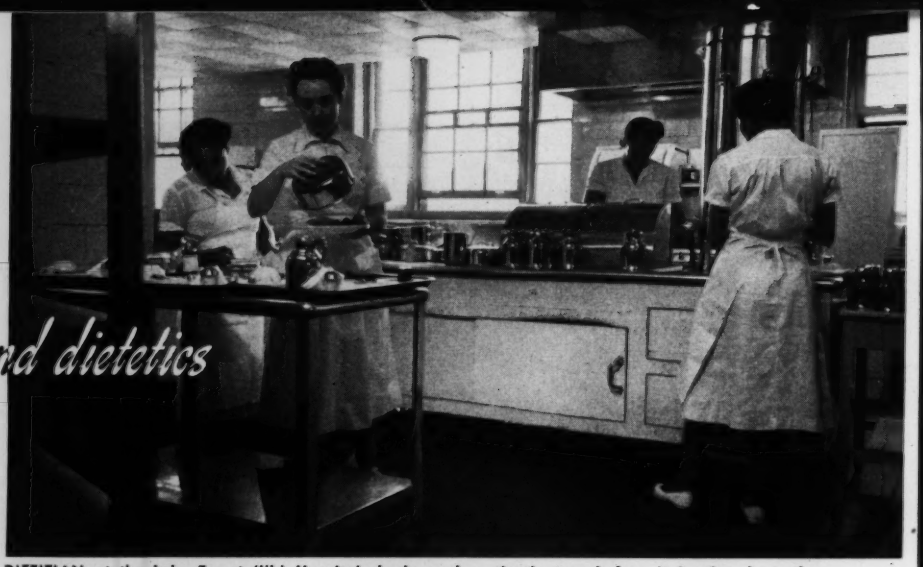
food service and dietetics



DIETITIAN at the Lake Forest (Ill.) Hospital checks each patient's tray before it is placed on the dumbwaiter. Since she visits each patient daily, she can actually personalize the food for each patient each day. If the patient is about to be discharged, she will see that he receives a generous portion; if he is on his first full meal after surgery, she will reduce the serving portions.

we made our limited bed complement an asset in . . .

personalizing patient food service

by RUTH WILEY

In a smaller hospital the dietitian often has a better opportunity to get to know her patients' food likes and dislikes and to personalize the menu for each patient. The author states, however, that without the assistance of an excellent chef, the cooperation of the medical and nursing staffs and many other factors, a personalized food service would be impossible.

A SMALL hospital presents many opportunities to personalize food service. At the 65-bed Lake Forest (Ill.) Hospital, there are many factors in the physical plant and in administrative policies of the hospital that make it possible for us to cater to the individual tastes of our patients.

Our well equipped kitchen, which was installed when the hospital was built 15 years ago, is our first great asset. It is large and well lighted with an adjoining large serving area from which centralized tray service is efficiently carried out.

A selective menu for the following day is placed on the breakfast trays of all patients on normal diets. The patient generally marks and returns this menu on the same tray. Occasionally a patient says, "Everything is good here and I like to be surprised."

We have found that a great choice of foods is not necessary. Familiar items, well prepared and attractively served, seem to be the solution.

Since hospitals are generally known for good or poor food, Lake Forest Hospital, through the years, has tried to earn a reputation for good food. In order to achieve and maintain such a reputation, we consider the following to be important: excellent chef, flexible food budget, centralized tray service, cooperation of the nursing department, written diet requests, selective menu, adequate instruction to patients, and the assistance of the women's auxiliary.

Ruth Wiley is chief dietitian of the Lake Forest (Ill.) Hospital.

EXCELLENT CHEF ESSENTIAL

Our chef who has been with us for more than 10 years is known to almost everyone in our community of 9,000 as "Joe". He takes great pride in his work, is extremely capable and cooperative. Often patients request his recipes or write personal thank-you notes to the dietary department.

Our board of directors has not specifically budgeted the dietitian, feeling that her main objective is satisfied, well fed patients. At a monthly meeting when the directors check the food costs with the hospital superintendent, they are made aware of the dietitian's attempt to improve patient satisfaction by correcting complaints.

We mail a questionnaire to the patient after his return home. One of the questions is: "During my stay in Lake Forest Hospital, I particularly noticed these things about the meals. . ." The replies are very helpful to us in improving our food service.

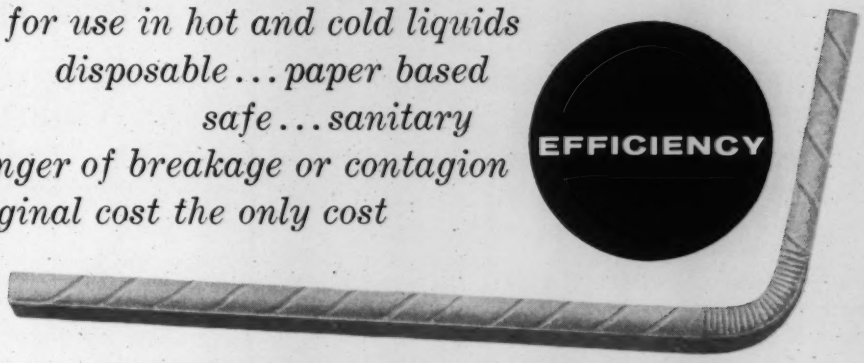
With few exceptions, the personnel are served the same menus as the patients. This pays off in good employee morale. Our labor turnover and absenteeism are comparatively low as our employees appreciate pleasant working conditions and personal recognition. Vacancies, when they do occur, are generally filled by an acquaintance of one of our personnel.

CENTRALIZED TRAY SERVICE

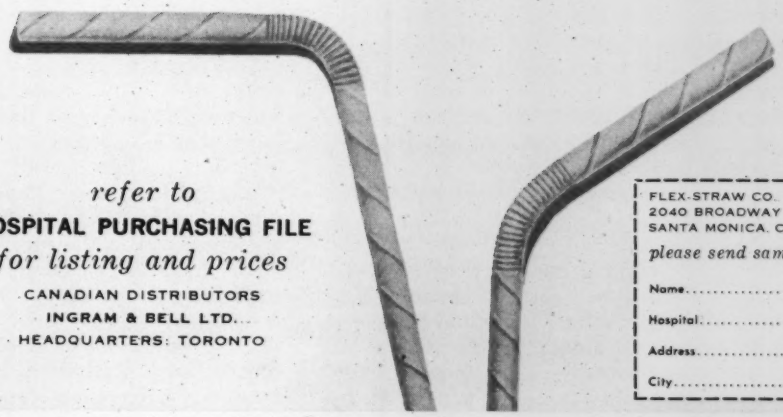
Our centralized tray service, perfected with the help of the nursing staff, is of great importance in personalizing each patient's menu. The dietitian supervises the serving of each tray and checks each menu for accuracy and detail. Since she knows each patient personally, she can request

best from every angle

bends to any angle
for use in hot and cold liquids
disposable... paper based
safe... sanitary
no danger of breakage or contagion
original cost the only cost



the drinking tube that has everything



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double portions for patients with large appetites, obstetrical patients and college athletes. She can tell at a glance that the average portion will be far too generous for the new patient who is taking solid food for the first time after surgery. Since the dietitian visits each patient, it is even possible for her to know that some patients on surgical liquids prefer chicken broth rather than consomme, cherry gelatin instead of the orange variety.

NURSING STAFF'S COOPERATION

When the dietitian makes her daily rounds, she stops at the nurses' station and is given a brief report from the nurse in charge concerning patients' attitudes, progress and personalities. This is especially helpful to the dietitian in making her first visits to patients.

This spirit of interdepartmental cooperation is a great asset, especially during the serving periods. We serve an average of 60 trays in 30 minutes. Trays are sent, four at a time, on a dumbwaiter to the floor serving kitchen where a member of the nursing staff immediately carries them to the patients' rooms.

An intercommunications system between the main kitchen and the floor serving kitchens is helpful in conveying last-minute requests or changes.

WRITTEN DIET REQUESTS

Written diet requests are sent to the main kitchen on the dumbwaiter. The patient's name, age, diagnosis, doctor's name and diet order are recorded. The cooperation of the medical staff in formulating the *Lake Forest Hospital Diet Manual* has been helpful in this regard. A copy of the manual can be found at each nurses' station.

The dietitian needs a cooperative medical staff with whom she can discuss individual patients' diet histories. During the morning hours, the doctors may suggest or request the dietitian to visit specific patients with them to discuss diet changes.

Our surgical staff doctors frequently order postoperative diets thus: "Fluids and diet as tolerated" or "Diet as desired", knowing that the patient will be visited personally and tempted to eat. These orders, of course, vary with the type of surgery done.

SELECTIVE MENU

A selective menu keeps the dietitian alert in planning menus to meet patients' individual preferences as well as the doctor's dietary restrictions. We write our menus one week in advance. Although there are few choices on the typed menus which the patient receives, he is always told by the dietitian on her visit that he is free to request a substitute for any item. The available choices are made known to him. Surprisingly few changes are made on the original menu, but the patient is invariably pleased to know the possibilities.

Broiled fillets, chops and chicken are the items most frequently requested and sherbet is the favorite dessert. There is no additional charge for food substitutes.

We have found, too, that selective menus have been an economy for us by cutting food waste.

INSTRUCTION TO PATIENTS

During her daily visits to patients, the dietitian has an opportunity to teach adequate as well as therapeutic diets. It is amazing how eager most patients are to discuss proper selection of a low calorie diet or the possibilities for variety in their husband's salt-restrictive foods.

All patients are given equal service and attention, if desired. However, a special effort is made to assure all patients on therapeutic diets that there is a specific reason for all restrictions and a detailed explanation is given as soon as the patient is able to respond. This helps to eliminate the partaking of such delicacies as candy and fresh fruit.

As much menu choice as possible is given to patients on restricted diets. A card file is kept in the dietitian's office with each patient's diet order as well as his preferences and idiosyncrasies. These guides are invaluable in writing daily therapeutic diets and in eliminating repetition of questions when making rounds.

Our women's auxiliary deserves a great amount of credit in eliminating two major hospital food problems—keeping hot foods hot and cold foods cold. The auxiliary has provided our dietary department with insulated coffee pots and insulated serving bowls, which are necessary for hot cereals, soups and ice creams.

We might add that our patients, who also take great pride in our hospital, do not pack these items for personal souvenirs. Our yearly inventory remains surprisingly accurate.

Recently a surgical patient said to me when I was making rounds: "This is the finest hospital I've ever seen. Everyone is so nice. Whoever hires the personnel must have an excellent insight into human nature." This, we believe, is the basis for all our compliments and efficiency: a board of directors with a personal and active interest in hospital affairs; a superintendent with complete confidence in the ability of her departmental heads; and an adequate and friendly staff who takes personal pride in their hospital. ■

Notes and Comment

New color filmstrip records Cornell findings on turkey

A filmstrip on the nutritional values of turkey as discovered in recent research at Cornell University has recently been released by the National Turkey Federation.

Produced by the federation in cooperation with the Poultry and Egg National Board, *Eat Turkey . . . Feel Perky* is a 14-minute, 35 mm color film. It is accompanied by a sound disc and an illustrated, printed commentary. Both filmstrip and sound disc are made for use with standard filmstrip projectors and sound equipment.

The filmstrip gives a complete report on the Cornell findings, which show turkey as the highest in protein and among the lowest in caloric content of all popular poultry and red meats. Many colorful and appetizing turkey dishes are presented in the film.

The filmstrip, sound record and commentary are priced at $3.75 and can be secured from the National Turkey Federation, Mount Morris, Ill. The filmstrip may also be obtained on a loan basis direct

An evaporated milk formula costs half as much as a proprietary formula and it supplies additional benefits. The considerable savings, over the formula period, can be important to many young parents.

The physician specifying an evaporated milk formula does so for its nutritional adjustability compared to the inflexible proprietary formula, not on a cost basis. Economy is purely a secondary benefit.

Young parents appreciate the doctor's counsel even more when they learn that the evaporated milk formula he *prescribes* as best for baby, brings worthwhile savings as well.

Carnation

"FROM CONTENTED COWS"

Optimum prescription-quality in today's trend to the individualized formula.

from the federation or from some of its affiliated state turkey federations. ■

Sponsor course by mail for food service supervisors

The Hospital Association of Pennsylvania and the Pennsylvania State Dietetic Association will sponsor an extension correspondence course for hospital food service supervisors later this year. The course will be offered by the Pennsylvania State University Extension Service for high school graduates in any state with supervisory ability and leadership and an interest in food preparation and service. The applicants must be employed in an accredited hospital or the hospital must be a member of the state hospital association with an acceptable dietary department under an ADA dietitian.

The three-fold purpose of the course is: to train qualified young women to assist hospital dietitians in supervision of food service for patients and personnel; to make available to the dietitian in urban and rural areas and the small hospital without a dietitian the services of trained nonprofessional supervisors; and to assist the trainee in attaining economic security.

Trainees will be employed as members of dietary departments during a one-year period of training. Correspondence lessons will include the following subjects: orientation and nutrition, quantity food preparation, food service to patients and personnel, and office routine and supervisory techniques. On-the-job training will include the following: orientation, two months; food production, three months; food service, four months; office routine, six weeks; supervisory techniques, six weeks.

All inquiries should be directed to the Hospital Association of Pennsylvania or the Pennsylvania State Dietetic Association. ■

Fall Cycle Menu for the Midwest

THE 21-DAY selective fall cycle menu and market orders for perishables are designed for hospitals in the Midwest. These menus, which are to be used during September, October and November, feature foods popular in Midwest.

The menus in this issue are the first in a four-part series of fall

cycle menus published in this Journal. Fall cycle menus for the South-Southwest will be included in the July 16 issue of **HOSPITALS**, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION. The fall menus for hospitals in the East and North-Northwest will be published in the August 1 and 16 issues, respectively.

During July and August hospitals are to use the summer cycle menus, published in the April and May 1957 issues of this Journal. The Midwest and South-Southwest cycle menus were included in the April 1 and 16 issues, respectively. The May 1 and 16 issues featured cycle menus for the East and North-Northwest, respectively.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. Moreover, a moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item can be served on both the full and soft diets.

In adapting items marked (S) for use on modified diets, it should be noted that certain items will need sodium or fat restriction during preparation, if they are to be served to patients on sodium or fat restrictive diets. When fruits are included on the dessert menu, the dietitian will omit sugar or substitute the water-packed variety for the diabetics.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry, and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The amounts are computed on the basis of serving 100 patient and personnel meals at breakfast, 125 at noon and 100 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other pre-prepared items.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

This list of supplies was published on page 73 of the January 1 issue of this Journal. The standard is also available upon request from the Association, 18 E. Division St., Chicago 10, Ill.

STEAM CHEF

"Side-by-Side"

CAFETERIA PAN STEAM COOKER

Adds Convenience...Versatility...Safety and Speed to Food Preparation

A Size and Style for Every Kitchen
GAS, ELECTRIC OR DIRECT STEAM OPERATED

This new series "Twelve-Twenty" Cafeteria Pan steam cooker, features cafeteria pans side-by-side. It accommodates two standard 12 x 20 inch cafeteria pans on each shelf, total capacity is 6 pans per steaming compartment.

The new "Side-by-Side" steamer readily accommodates 12 x 20 inch containers of 4, 6, or 8 inch depths and 18 x 26 inch flat bake trays.

Lower steaming compartments simplify handling of all containers. Every compartment is easy to reach. The "Side-by-Side" steamer is available in two, three, and four compartment units: also in models for gas, electric, or direct-connected steam operation.

For complete detailed information and specifications write to:

THE CLEVELAND RANGE CO.
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For 11 consecutive years most winners in the "Institutions" Food Service Contest Have Steam-Chef Kitchens!

Self-generating model 2SF Steam Chef.

1st WEEK MIDWEST SELECTIVE FALL CYCLE MENU—prepared by Charlotte Ludwig, associate director, dietary department, Michael Reese Hospital, Chicago

MENUS TO BE USED DURING SEPTEMBER, OCTOBER AND NOVEMBER

	breakfast	noon	night
monday	Orange Sections **or** Prune Juice Oatmeal **or** Puffed Wheat Cereal Soft Cooked Egg	Vegetable Soup Baked Macaroni and Cheese (FS) **or** Braised Veal Club Steak Creamed Potatoes Buttered Asparagus (FS) **or** Creole Celery Romaine and Endive Salad—Chiffonade Dressing **or** Pineapple-Date Salad with Mayonnaise Stewed Red Cherries (FS) **or** Lime Sherbet	Chilled Fruit Punch Pot Roast of Beef with Gravy (FS) **or** Baked Canadian Bacon Parsley Buttered Potatoes (FS) Buttered Peas (FS) **or** Buttered Seven-Minute Cabbage Molded Gingerale Salad—Mayonnaise **or** Sliced Tomato Salad—French Dressing Caramel Iced Spice Cake (FS) **or** Nectarines in Syrup
tuesday	Grapefruit Juice **or** Applesauce Whole Wheat Cereal **or** Corn Flakes French Toast/Syrup (F) Soft Cooked Egg (S)	Chilled Orange-Pineapple Juice Meat Loaf with Gravy (F) **or** Turkey Cubes in Sauce Supreme on Rusk (S) Whipped Potatoes (FS) Buttered Julienne Carrots (FS) **or** Buttered Broccoli Head Lettuce Salad with 1000 Island Dressing **or** Stuffed Prune Salad Rhubarb Crisp (F) **or** Whole Peeled Apricots in Syrup (S)	Alphabet Soup Roast Leg of Lamb with Gravy (FS) **or** Shortribs of Beef in Gravy Oven Browned Potatoes (FS) Buttered Green Beans (FS) **or** Buttered Diced Turnips Minted Pear Salad **or** Celery Cabbage Salad—Celery Seed Dressing Old Fashioned Strawberry Shortcake (F) **or** Vanilla Ice Cream (S)
wednesday	Orange Juice **or** Frozen Peaches Rolled Wheat Cereal **or** Ready-to-Eat Rice Cereal Scrambled Eggs	Consomme with Egg Drops Beef, Potato and Vegetable Stew (F) **or** Broiled Salmon Steak-Lemon Wedge (S) Baked Potato (S) Buttered Whole Kernel Corn (F) **or** Buttered Spinach (S) Grapefruit Sections on Endive/Honey Lime Dressing **or** Pickled Beet Salad Chocolate Brownie (F) **or** Fruited Gelatin (S)	Cranberry Juice Cocktail Roast Loin of Pork with Gravy (F) **or** Ground Steak Patty (S) Paprika Potato Cubes (FS) Baked Squash (FS) **or** Buttered Brussel Sprouts Waldorf Salad **or** Marinated Cucumber Salad Lemon Meringue Pudding (FS) **or** Italian Plums in Syrup
thursday	Stewed Prunes **or** Grapefruit Juice Farina **or** Ready-to- Eat Malt Flake Cereal Soft Cooked Egg Sally Lunn Coffee Cake	Consomme Julienne Brisket of Beef (FS) Horseradish (F) **or** Braised Lamb Shoulder Steak—Mint Jelly Parsley Buttered Potatoes (FS) Stewed Tomatoes (FS) **or** Buttered Asparagus Herb Coleslaw **or** Apricot-Toasted Coconut Salad Vanilla Ice Cream (FS) **or** Bunch of Fresh Grapes	Chilled Blended Juice Stewed Chicken with Dumplings (FS) **or** Scrambled Eggs with Sausage Links Steamed Potato in Jacket Buttered Peas (FS) **or** French Fried Eggplant Chef's Salad with Chef's Dressing **or** Sliced Orange Salad with Fruit French Dressing Apple Pie (F) **or** Sliced Peaches in Syrup (S)
friday	Grapefruit Half **or** Pineapple Juice Whole Wheat Cereal **or** Puffed Rice Cereal Soft Cooked Egg	Cream of Mushroom Soup Shrimp Salad Plate with Potato Chips and Tomato Garnish (F) **or** Boiled Beef (S) Buttered Noodles (S) Buttered Broccoli (F) **or** Parslied Wax Beans (S) Celery Hearts and Radishes on Lettuce **or** Molded Cucumber-Lime Salad—Mayonnaise Chilled Fruit Cup (F) **or** Baked Custard (S)	Chilled Lime-Apricot Cocktail Swiss Steak (F) **or** Broiled Halibut in Lemon Butter (S) Parsley Buttered Potatoes (FS) Buttered Carrot Coins (FS) **or** Cream Style Corn Tossed Greens—Lorenzo Dressing **or** Pear and Grape Salad with Mayonnaise Lazy Daisy Cake (F) **or** Bing Cherries in Syrup (S)
saturday	Orange Juice **or** Kadota Figs in Syrup Farina **or** Shredded Wheat Cereal Sausage Links (F) Soft Cooked Egg (S)	Chicken Rice Soup Shepherd's Pie (F) **or** Oven Broiled Liver in Gravy (S) Whipped Potatoes (S) Buttered Zucchini (FS) **or** Buttered Mixed Vegetables Sliced Tomato Salad—Mayonnaise **or** Peach Salad—Raisin-Nut Roll Center Lemon Sherbet (FS) **or** Green Gage Plums in Syrup	Chilled Grape Juice Punch Roast Leg of Veal with Gravy (FS) **or** Cottage Cheese-Fruit Bowl Baked Potato (FS) Harvard Beets (FS) **or** Buttered Cauliflower Mixed Raw Vegetable Salad—French Dressing **or** Spiced Crabapple Salad Tapioca Pudding (FS) **or** Pineapple Chunks in Syrup
sunday	Sliced Banana **or** Grapefruit Juice Oatmeal **or** Corn Flakes Bacon Sweet Roll	Mulled Cider Roast Turkey with Giblet Gravy (FS) **or** Baked Pork Chop Glazed Sweet Potato (FS) Buttered Spinach (FS) **or** Buttered Pearl Onions Molded Raw Cranberry Relish Salad—Mayonnaise **or** Head Lettuce Salad with Bleu Cheese Dressing Orange Iced Chiffon Cake (FS) **or** Bartlett Pears in Syrup	Mulligatawny Soup Hot Roast Beef Sandwich with Gravy (FS) **or** Assorted Cold Cuts with Potato Salad Buttered Baby Lima Beans (F) **or** Mashed Squash (S) Carrot Sticks and Pickle Slices on Lettuce **or** Citrus Salad with Fruit French Dressing Strawberry Ice Cream (FS) **or** Peaches in Syrup

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

1st week market order for perishables (per 50 beds)

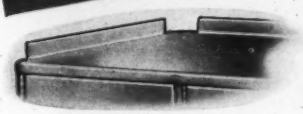
Item, Specifications, Amounts & No. of Servings			
BEEF			
Bologna	All beef	5 lbs.	
Brisket, Fresh	U. S. Good	40 lbs.	120
Butt, Bottom (B.R.T.)	U. S. Good	35 lbs.	105
Chuck-eye Roll (Boneless)	U. S. Good	20 lbs.	80
Ground Beef	U. S. Good, 5 lb. pkg.	50 lbs.	225
Liver	Steer, sliced	5 lbs.	25
Salami (Soft)	All beef	5 lbs.	
Short Ribs	U. S. Good	10 lbs.	20
Steak, Swiss	U. S. Good, 4 oz. each	25 lbs.	100
Stew	U. S. Good	20 lbs.	100
LAMB			
Chops, Shoulder	U. S. Good, 5 oz. each	10 lbs.	30
Leg (B.R.T.)	U. S. Choice, yearling	30 lbs.	90
PORK			
Bacon, Canadian		5 lbs.	25
Bacon (Sliced)	24-26-1 lb.	12 lbs.	144
Chops, Loin	Grade A, 4 oz. each	5 lbs.	20
Loin (Boneless)	Grade A, 10-12 lbs.	30 lbs.	90
Sausage Links	12-1 lb.	30 lbs.	120
VEAL			
Leg (B.R.T.)	U. S. Good	25 lbs.	75
Steaks, Club	U. S. Good, 5 oz. each	10 lbs.	30
FISH			
Halibut	Steaks, 5 oz. each	10 lbs.	30
Salmon	Red, steaks, 5 oz. each	10 lbs.	30
Shrimp	26-28-1 lb.	20 lbs.	100
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	70 lbs.	90
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	80 lbs.	
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Bananas	Ripe	30 lbs.	90
Grapefruit	Seedless, 70s	2 Boxes	280
Grapes	Emperor	30 lbs.	
Lemons		3 doz.	
Oranges	176s	1 box	
FRESH VEGETABLES			
Cabbage	Bag	100 lbs.	
Cabbage, Celery		6 heads	
Carrots	Topped, bag	100 lbs.	
Celery	Pascal, 30s	1 crate	
Chicory	Bunch	6 bunches	
Cucumbers		4 doz.	
Eggplant		2 only	
Lettuce	Head, 48s	2 crates	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Parsley	Bunch	1 doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	300 lbs.	
Radishes	Bunch	2 doz.	
Romaine	Head	6 heads	
Squash, Acorn		20 lbs.	
Squash, Zucchini		20 lbs.	
Tomatoes	Repacked (5x6)	2 Lugs (60 lbs.)	
Turnips, White	Topped	5 lbs.	
FROZEN FRUITS			
Apples	8 lb. can	24 lbs.	
Cherries	8 lb. can, 5-1 sugar	24 lbs.	100
Grapefruit Juice	Con., 32 oz. can	6 cans	192
Orange Juice	Con., 32 oz. can	6 cans	192
Strawberries	Sliced, 8 lb. can, 5-1 sugar	16 lbs.	
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	15 lbs.	90
Asparagus	Spears, 2½ lb. pkg.	2½ lbs.	15
Beans, Green	Cuts, 2½ lb. pkg.	15 lbs.	90
Beans, Lima	Small, green, 2½ lb. pkg.	15 lbs.	90
Beans, Wax	Cuts, 2½ lb. pkg.	2½ lbs.	15
Broccoli	Stems and buds 2½ lb. pkg.	17½ lbs.	105
Brussel Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	30 lbs.	180
Spinach	Chopped, 2½ lb. pkg.	30 lbs.	180
Squash, Winter	3 lb. pkg. 1 lb. pkg.	2 lbs.	
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

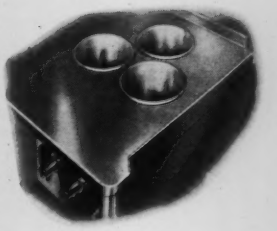
NEW *Ideal* MEALMOBILE with...

MECHANICALLY REFRIGERATED COLD SECTION with Built-in BEVERAGE DISPENSER

The cold section of the new IDEAL Mealmobile gives you a refrigerator on wheels . . . eliminates the problem of handling and freezing dole plates. A unique blower arrangement maintains an even temperature, selected by thermostat, throughout the cold compartment.

The IDEAL Model 9020 BCT delivers with "kitchen control" 20 meals of hot and cold foods and dispenses both hot and cold liquids. This new IDEAL Mealmobile is truly a new plus in food serving efficiency!





SEAMLESS TOP GUARD

Eliminates dirt catching crevices. Open corners permit easy cleaning. Extended edge of guard prevents articles carried on top deck from sliding off in transit.

BEVERAGE DISPENSER

Exclusive Ideal built-in beverage dispensers feature individual thermostatic control. Thoroughly insulated from each other and from the remainder of the cart, they can carry both hot and cold liquids. Each well has 5½ quart capacity.

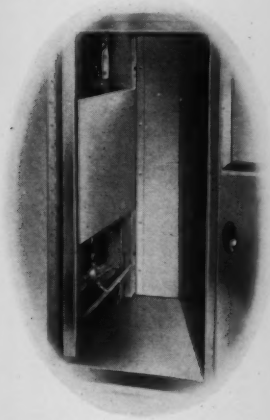
REFRIGERANT COMPRESSOR

The ¼ H.P. refrigerant compressor is protected by a 20 ga. stainless steel housing. Thermostat on compressor housing permits selection of cold compartment temperature. Switch permits blower in cold compartment to be turned off when doors to cold section are open.

Model 9020BCT

LOCK SEAMED INSULATED DOORS

Exclusive Ideal overlapping doors provide positive seal regardless of temperature extremes. Easy to open and close. Glass fiber insulation reduces temperature change inside compartments.



NO-TIP TRAY GUIDES

Exclusive "no-tip" guides allow tray to be pulled out all the way and kept level for drawer-to-tray serving without lifting tray to top deck. Affords speedier service and less chance for error.

SUPER SIZE DRAWERS

Seven heavy gauge aluminum drawers in the heated section. Each holds three 9" plates plus three side serving dishes. Safety stops and name card holders.

MECHANICAL COOLING

A unique blower-coil arrangement keeps temperature within the cold-compartment even throughout. Drip trough and cup catch water resulting from condensation . . . eliminate puddles on bottom of cold section.

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HOSPITAL EQUIPMENT
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SWARTZBAUGH MANUFACTURING COMPANY
MURFREESBORO, TENN.

2nd WEEK MIDWEST SELECTIVE FALL CYCLE MENU—prepared by Charlotte Ludwig, associate director, dietary department, Michael Reese Hospital, Chicago

MENUS TO BE USED DURING SEPTEMBER, OCTOBER AND NOVEMBER

	breakfast	noon	night
monday	Stewed Fruit Compote **or** Orange Juice Whole Wheat Cereal **or** Puffed Rice Cereal Soft Cooked Egg	Beef Barley Soup Grilled Hamburger on a Bun with Catsup (F) **or** Baked Cheese Souffle with Parsley Sauce (S) Steamed Potato in Jacket (S) Buttered Broccoli (F) **or** Buttered Beets (S) Sweet-Sour Cucumbers **or** Blush Pear Salad with Mayonnaise Frozen Boysenberries (F) **or** Chocolate Covered Graham Crackers (S)	Chilled Pear-Lime Nectar Baked Breaded Veal Cutlet (FS) **or** Broiled Haddock—Lemon Wedge Parsley Buttered Potatoes (FS) Buttered French Style Green Beans (FS) **or** Stewed Tomatoes Peanut Coleslaw **or** Pineapple Salad-Cherry Garnish Cream Puff (F) **or** Chilled Applesauce (S)
tuesday	Grapefruit Sections **or** Apricot Nectar Rolled Wheat Cereal **or** Bran Flake Cereal Scrambled Eggs	Chilled Pineapple Juice Chop Suey with Toasted Noodle Garnish (F) **or** Ground Beef Patty (S) Buttered Fluffy Rice (FS) Buttered Asparagus (FS) **or** Buttered Whole Kernel Corn Romaine and Endive Salad with Oil and Vinegar Dressing **or** Sliced Orange-Coconut Salad Royal Anne Cherries in Syrup (FS) **or** Baked Custard	Noodle Soup Oven Broiled Chicken (FS) **or** Sauteed Sweetbreads and Mushrooms Whipped Potatoes (FS) Buttered Julienne Carrots (FS) **or** Buttered Brussel Sprouts Spiced Peach Salad **or** Sliced Tomato Salad—French Dressing Old Fashioned Fruit Bars (FS) **or** Green Gage Plums in Syrup
wednesday	Orange Juice **or** Kadota Figs in Syrup Farina **or** Wheat Flake Cereal Soft Cooked Egg Glazed Doughnut (F)	Vegetable Soup Braised Lamb Shoulder Steak (FS) **or** Turkey Salad—Ripe Olive Garnish Baked Potato (FS) Buttered Peas (FS) **or** Buttered Mashed Turnips Radishes and Carrot Sticks on Lettuce **or** Grapefruit Sections on Endive—Fruit French Dressing Chocolate Ice Cream (FS) **or** Nectarines in Syrup	Chilled Tomato Juice Roast Sirloin of Beef Au Jus (FS) **or** French Fried Scallops-Tartar Sauce Paprika Potato Cubes (FS) Buttered Spinach (FS) **or** Buttered Baby Lima Beans Chef's Salad with Chef's Dressing **or** Perfection Salad with Mayonnaise Pumpkin Pie (F) **or** Fruit Cocktail in Syrup (S)
thursday	Sliced Oranges **or** Pineapple Juice Whole Wheat Cereal **or** Corn Flakes Griddle Cakes with Syrup (F) Soft Cooked Egg (S)	Chilled Spiced Apple Juice Roast Leg of Veal with Gravy (FS) **or** Creamed Chipped Beef on Rusk Snowflake Potatoes (FS) Parslied Wax Beans (FS) **or** Buttered Cauliflower Head Lettuce Salad—Chiffonade Dressing **or** Mixed Fruit Salad—Whipped Cream Dressing Yellow Cake with Butterscotch Sauce (FS) **or** Bartlett Pears in Syrup	Alphabet Soup Barbecued Spareribs (F) **or** Chicken Fricassee (S) Oven Browned Potatoes (FS) Mashed Squash (FS) **or** French Fried Eggplant Celery Cabbage Salad with Celery Seed Dressing **or** Stuffed Apricot Salad Lime Sherbet (FS) **or** Bing Cherries in Syrup
friday	Grapefruit Juice **or** Stewed Rhubarb in Syrup Oatmeal **or** Shredded Wheat Cereal Soft Cooked Egg	Chilled Fruit Punch Tuna Tetrazzini (F) **or** Ground Lamb Patty (S) Baked Potato (S) Stewed Tomatoes (FS) **or** Buttered Carrot Coins Tossed Greens—Lorenzo Dressing **or** Orange Sections on Endive with Fruit-French Dressing Pineapple Slices in Syrup (FS) **or** Blueberry Cobbler	Cream of Asparagus Soup Hot Sliced Corned Beef (F) **or** Broiled Perch—Lemon Wedge (S) Parsley Buttered Potatoes (FS) Buttered Seven-Minute Cabbage (F) **or** Buttered Peas (S) Celery Hearts and Stuffed Olives on Lettuce **or** Pear Salad—Marshmallow Dressing Fresh Grapes, Cream Cheese and Crackers (F) **or** Apricot Whip (S)
saturday	Sliced Banana **or** Orange Juice Whole Wheat Cereal **or** Ready-to-Eat Rice Cereal Bacon	Philadelphia Pepperpot Braised Tenderloin Tips with Mushrooms (F) **or** Fluffy Omelet—Jelly (S) Steamed Potato in Jacket (FS) Buttered Asparagus (FS) **or** Buttered Mixed Vegetables Sliced Tomato Salad—French Dressing **or** Stuffed Prune Salad Baked Apple (FS) **or** Homemade Ginger Snaps	Chilled Blended Juice Pot Roast of Beef with Gravy (FS) **or** Oven Broiled Liver in Onion Gravy Paprika Potatoes (FS) Buttered Sliced Beets (FS) **or** Buttered Zucchini Old Fashioned Coleslaw **or** Molded Pineapple-American Cheese Salad—Mayonnaise Vanilla Ice Cream with Butterscotch Sauce (FS) **or** Sliced Peaches in Syrup
sunday	Grapefruit Half **or** Prune Juice Farina **or** Puffed Wheat Cereal Soft Cooked Egg Sweet Roll	Chilled Cranberry-Gingerale Cocktail Grilled Ham Steak (F) **or** Roast Leg of Lamb—Mint Jelly (S) Scalloped Potatoes (FS) Buttered Whole Kernel Corn (F) **or** Baked Acorn Squash (S) Waldorf Salad **or** Chef's Salad with Chef's Dressing Chocolate Marshmallow Roll (FS) **or** Italian Plums in Syrup	Split Pea Soup Salisbury Steak (F) **or** Open Faced Sliced Turkey Sandwich with Cheese Sauce (S) French Fried Potatoes (F) Buttered Green Beans (FS) **or** Braised Celery Marinated Cauliflower Salad **or** Spiced Peach Salad Citrus Fruit Cup (F) **or** Raspberry Sherbet (S)

F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Corned	U. S. Good	30 lbs.	90
Butt, Bottom (B.R.T.)	U. S. Choice	35 lbs.	105
Butt, Bottom Sirloin (B.R.T.)	U. S. Good	30 lbs.	90
Chipped Beef, Dried	U. S. Good	2 lbs.	20
Ground Beef	U. S. Good, 5 lb. pkg.	60 lbs.	240
Liver	Steer, sliced	5 lbs.	25
Tenderloin Tips	U. S. Good	25 lbs.	100
LAMB			
Chops, Shoulder	U. S. Good, 5 oz. each	35 lbs.	105
Ground, Shoulder	U. S. Good	5 lbs.	20
Leg (B.R.T.)	U. S. Choice, yearling	5 lbs.	15
PORK			
Bacon (Sliced)	24-26-1 lb.	6 lbs.	72
Chop Suey Cut	Grade A	10 lbs.	50
Ham (Pullman)	Ready-to-eat	20 lbs.	80
Spareribs	Grade A, 3-1 lb.	40 lbs.	80
VEAL			
Cutlets	U. S. Good, 4 oz. each	25 lbs.	100
Leg (B.R.T.)	U. S. Good	30 lbs.	90
Stew	U. S. Good	10 lbs.	50
Sweetbreads	Fresh	5 lbs.	20
FISH			
Halibut	Steaks, 5 oz. each	5 lbs.	15
Perch (Ocean	Fillets	10 lbs.	40
Scallops		5 lbs.	25
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	10 lbs.	15
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	24 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	60 lbs.	100
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Bananas	Ripe	30 lbs.	90
Grapes	Emperor	28 lbs.	
Lemons		1 doz.	
Oranges	176s	1 crate	
FRESH VEGETABLES			
Cabbage	Bag	100 lbs.	
Carrots	Topped, bag	100 lbs.	
Celery	Pascal, 30s	2 crates	
Celery Cabbage	Heads	6 heads	
Chicory	Bunch	6 bunches	
Cucumbers		2 doz.	
Eggplant		2 only	
Lettuce	Head, 48s	2 crates	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Parsley	Bunch	1 doz.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Romaine	Head	6 heads	
Squash, Acorn		5 lbs.	
Squash, Zucchini		5 lbs.	
Tomatoes	Repacked (5x6)	1 lug (30 lbs.)	
Turnips, Yellow		5 lbs.	
FROZEN FRUITS			
Blueberries	Dry, 8 lb. can	16 lbs.	
Boysenberries	8 lb. can, 5-1 sugar	24 lbs.	
Grapefruit Juice	Con., 32 oz. can	6 cans	192
Grapefruit Sections	8 lb. can	8 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	192
Rhubarb	8 lb. can, 5-1 sugar	8 lbs.	
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	30 lbs.	180
Beans, Green	Cuts, 2½ lb. pkg.	30 lbs.	180
Beans, Lima	Small, green, 2½ lb. pkg.	2½ lbs.	15
Beans, Wax	Cuts, 2½ lb. pkg.	15 lbs.	90
Broccoli	Stems and buds 2½ lb. pkg.	15 lbs.	90
Brussel Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	17½ lbs.	105
Peas	2½ lb. pkg.	17½ lbs.	105
Spinach	Chopped, 2½ lb. pkg.	15 lbs.	90
Squash, Winter	3 lb. pkg., 1 lb. pkg.	15 lbs.	90
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

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- *SANITARY!*
- *DISPOSABLE!*

Plastic Straws are DURABLE and INEXPENSIVE. They never wilt in hot liquids and they will outlast paper 10 to 1.

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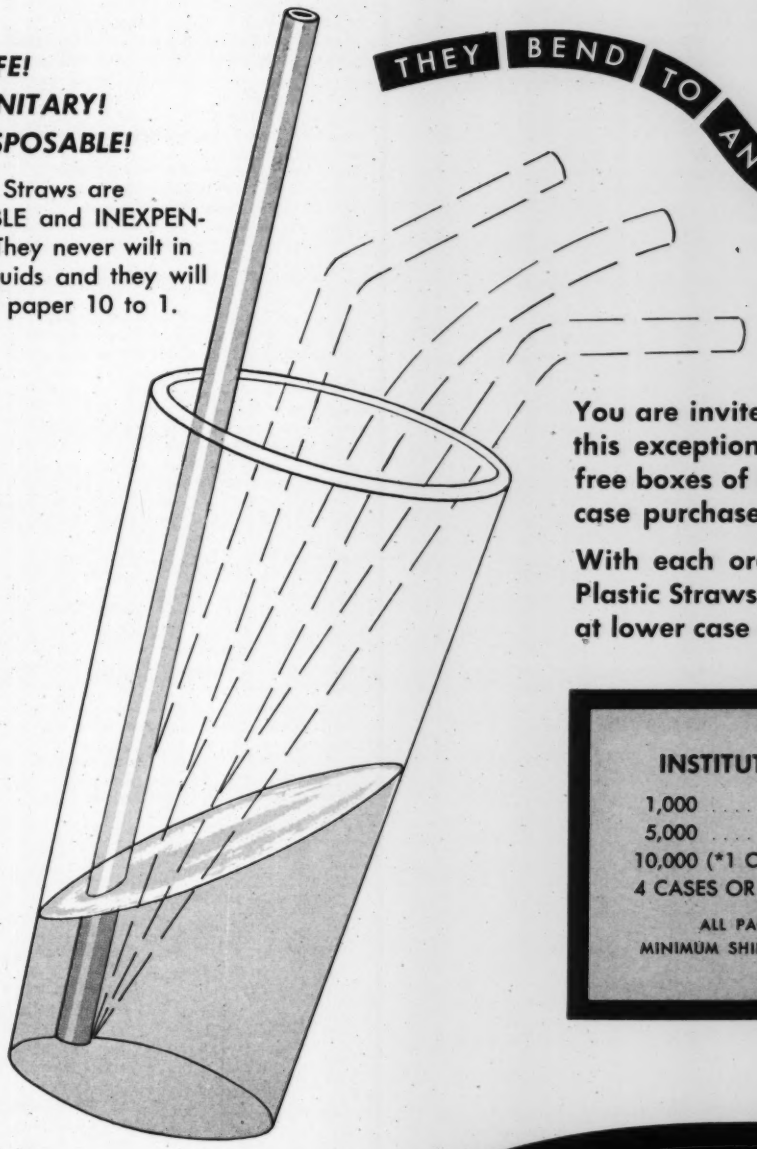

You are invited to take advantage of this exceptional limited offer of two free boxes of Plastic Straws with each case purchased.

With each order of *10,000 (1 case) Plastic Straws, you pay for only 9,000 at lower case lot price.

INSTITUTIONAL PRICE LIST

1,000	$4.75 PER 1,000
5,000	4.50 PER 1,000
10,000 (*1 CASE)	4.25 PER 1,000
4 CASES OR OVER	3.75 PER 1,000

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DPC

3rd WEEK MIDWEST SELECTIVE FALL CYCLE MENU—prepared by Charlotte Ludwig, associate director, dietary department, Michael Reese Hospital, Chicago

MENUS TO BE USED DURING SEPTEMBER, OCTOBER AND NOVEMBER

	breakfast	noon	night
monday	Orange Juice **or** Applesauce Rolled Oat Cereal **or** Bran Flake Cereal Soft Cooked Egg	Alphabet Soup Barbecued Beef on Bun (F) **or** Creamed Chicken on Rusk (S) Baked Potato (S) Buttered Spinach (FS) **or** Buttered Pearl Onions Tossed Greens—Oil and Vinegar Dressing **or** Grapefruit-Avocado Salad—French Dressing Whole Peeled Apricots in Syrup (FS) **or** Whipped Gelatin	Chilled Pineapple Juice Potted Steak (FS) **or** Tunafish Salad Plate with Shoestring Potatoes Whipped Potato (FS) Buttered Julienne Carrots (FS) **or** Buttered Seven-Minute Cabbage Celery Sticks and Radishes on Lettuce **or** Pear and Grape Salad—Mayonnaise Cherry Upside-down Cake (FS) **or** Sliced Banana in Fruit Juice
tuesday	Stewed Prunes **or** Grapefruit Juice Whole Wheat Cereal **or** Ready-to-Eat Rice Cereal Soft Cooked Egg	Chilled Peach-Orange Nectar Veal a la King on Cornbread (F) **or** Scrambled Eggs and Bacon Curls (S) Steamed Potato in Jacket (S) Buttered Peas (FS) **or** Buttered Cauliflower Pickled Beet and Onion Ring Salad **or** Molded Fruit Salad—Mayonnaise Fresh Pear (F) **or** Orange Sherbet (S)	Chicken-Rice Soup Roast Beef au Jus (FS) **or** Fresh Tongue—Horseradish Sauce Parsley Buttered Potatoes (FS) Pimiento Wax Beans (FS) **or** Stewed Tomatoes Cucumber In Sour Cream **or** Apricot Salad—Cherry Garnish Apple Brown Betty with Nutmeg Sauce (FS) **or** Pineapple Slices in Syrup
wednesday	Citrus Fruit Cup **or** Apricot Nectar Oatmeal **or** Puffed Wheat Cereal Soft Cooked Egg Coffee Cake	French Onion Soup with Croutons Escalloped Ham and Potatoes (F) **or** Ground Beef Patty (S) Buttered Fluffy Rice (S) Mashed Squash (FS) **or** Buttered Mixed Vegetables Garden Coleslaw **or** Peach-Apple Butter Salad Pineapple Ice Cream (FS) **or** Kadota Figs in Syrup	Chilled Cranberry Punch Baked Chicken with Gravy (FS) **or** Italian Spaghetti with Meat Balls—Grated Parmesan Cheese Baked Sweet Potato (FS) Buttered Asparagus (FS) **or** French Fried Eggplant Head Lettuce Salad with Chiffonade Dressing **or** Pear-Cottage Cheese Salad—Mayonnaise Sugared Gingerbread Square (FS) **or** Purple Plums in Syrup
thursday	Grapefruit Juice **or** Frozen Boysenberries Whole Wheat Cereal **or** Ready-to-Eat Wheat Flake Cereal Scrambled Eggs	Chilled Blended Juice Braised Veal Club Steak (FS) **or** Creole Chicken Livers Paprika Potatoes (FS) Buttered Green Beans (FS) **or** Buttered Diced Turnips Chef's Salad with Chef's Dressing **or** Golden Glow Salad—Mayonnaise Butterscotch Pudding (FS) **or** Royal Anne Cherries in Syrup	Vegetable Soup Roast Leg of Lamb with Gravy (FS) **or** Hungarian Goulash Buttered Noodles (FS) Buttered Sliced Beets (FS) **or** Buttered Brussel Sprouts Stuffed Celery Salad **or** Orange Sections on Endive—Honey-Lime Dressing Angel Food Cake with Frozen Peaches (F) **or** Applesauce (S)
friday	Sliced Banana **or** Orange Juice Farina **or** Puffed Rice Cereal Soft Cooked Egg	Cream of Pea Soup Salmon Loaf with Cucumber Sauce (F) **or** Broiled Butt Steak au Jus (S) Whipped Potatoes (FS) Buttered Whole Kernel Corn (F) **or** Buttered Zucchini (S) Celery Cabbage Salad with Celery Seed Dressing **or** Pineapple-Grated American Cheese Salad with Mayonnaise Green Gage Plums in Syrup (FS) **or** Date Square	Chilled Grape Juice Punch Turkey Pot Pie (F) **or** Broiled Halibut in Lemon Butter (S) Parsley Buttered Potatoes (FS) Buttered Broccoli (F) **or** Buttered Carrot Coins (S) Head Lettuce Salad-Lorenzo Dressing **or** Grapefruit and Red Apple Salad—Fruit-French Dressing Lemon Meringue Pie (FS) **or** Sliced Peaches in Syrup
saturday	Grapefruit Half **or** Prune Juice Rolled Wheat Cereal **or** Corn Flakes Soft Cooked Egg Bacon	Chilled Apple Juice Baked Pork Steak (F) **or** Baked Cheese Fondue (S) Scalloped Potatoes (F) Buttered Peas (FS) **or** Stewed Celery Asparagus-Pimiento Salad—Vinaigrette Dressing **or** Molded Cranberry Salad—Mayonnaise Vanilla Ice Cream (FS) **or** Bunch of Fresh Grapes	Beef Barley Soup Roast Leg of Veal with Gravy (FS) **or** Frankfurter on a Bun with Mustard Oven Browned Potatoes (FS) Buttered Spinach (FS) **or** Buttered Baby Lima Beans Sliced Tomato Salad with French Dressing **or** Ambrosia Salad with Mayonnaise Fruited Gelatin with Whipped Cream (FS) **or** Bartlett Pears in Syrup
sunday	Sliced Oranges **or** Pineapple Juice Farina **or** Ready-to-Eat Rice Cereal Soft Cooked Egg Sweet Roll	Chilled Fruit Juice Fizz Oven Broiled Chicken with Gravy (FS) **or** Spanish Steak Snowflake Potatoes (FS) Buttered French Style Green Beans (FS) **or** Baked Squash Spiced Crabapple Salad **or** Romaine and Endive with Oil and Vinegar Dressing Iced Marble Cake (FS) **or** Frozen Peaches	Consomme Julienne Beef Biscuit Roll-Mushroom Gravy (F) **or** Ground Lamb Patty-Mint Jelly (S) Creamed Potatoes (S) Buttered Seven-Minute Cabbage (F) **or** Buttered Beets (S) Carrot and Celery Sticks **or** Stuffed Prune Salad Bing Cherries in Syrup (FS) **or** Peppermint Ice Cream

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Butt, Sirloin (B.R.T.)	U. S. Choice	35 lbs.	105
Frankfurters	All beef, 8-1 lb.	5 lbs.	20
Ground Beef	U. S. Good, 5 lb. pkg.	25 lbs.	125
Round (Bottom)	U. S. Standard	30 lbs.	90
Steaks, Round	U. S. Choice, 4 oz. each	30 lbs.	120
Steaks, Sirloin Butt	U. S. Choice, 5 oz. each	10 lbs.	30
Steak, Swiss	U. S. Good, 4 oz. each	5 lbs.	20
Stew	U. S. Good	5 lbs.	25
Tongue	No. 1	5 lbs.	
LAMB			
Ground, Shoulder	U. S. Good	5 lbs.	20
Leg (B.R.T.)	U. S. Choice, yearling	30 lbs.	90
PORK			
Bacon (Sliced)	24-26-1 lb.	12 lbs.	144
Butts, Smoked (Boneless)	Lean	20 lbs.	80
Steaks (Boneless)	Grade A, 4 oz. each	25 lbs.	100
VEAL			
Leg (B.R.T.)	U. S. Good	30 lbs.	90
Shoulder (Boneless)	U. S. Good	25 lbs.	100
Steaks, Club	U. S. Good, 5 oz. each	35 lbs.	105
FISH			
Halibut	Steaks, 5 oz. each	10 lbs.	30
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	5 lbs.	20
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	40 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	120 lbs.	200
Livers, Chicken	1 lb. pkg.	3 lbs.	15
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Avocado	Ripe	6 only	
Bananas	Ripe	50 lbs.	
Grapefruit	Seedless, 70s	1 crate	
Grapes	Emperor	28 lbs.	
Grapes	Seedless, 28 lb. box	28 lbs.	
Lemons		2 doz.	
Oranges	176s	2 crates	
Pears	Box, 120s	1 box	
FRESH VEGETABLES			
Cabbage	Bag	100 lbs.	
Carrots	Topped, bag	100 lbs.	
Celery	Pascal, 30s	1 crate	
Celery Cabbage		6 heads	
Cucumbers		2 doz.	
Eggplant		2 only	
Endive	Curly	6 bunch	
Lettuce	Head, 48s	2 crates	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	2 doz.	
Parsley	Bunch	1 doz.	
Radishes	Bunch	6 heads	
Romaine		5 lbs.	
Squash, Zucchini		5 lbs.	
Tomatoes	Repacked (5x6)	1 lug (30 lbs.)	
Turnips, White	Topped	5 lbs.	
FROZEN FRUITS			
Boysenberries	8 lb. can, 5-1 sugar	8 lbs.	
Grapefruit Juice	Con., 32 oz. can	6 cans	
Orange Juice	Con., 32 oz. can	6 cans	
Peaches	Sliced, 8 lb. can, 5-1 sugar	32 lbs.	
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	15 lbs.	90
Beans, Green	Cuts, 2½ lb. pkg.	15 lbs.	90
Beans, Green	Julienne, 2½ lb. pkg.	15 lbs.	90
Beans, Lima	Small, green, 2½ lb. pkg.	2½ lbs.	15
Beans, Wax	Cuts, 2½ lb. pkg.	15 lbs.	90
Broccoli	Stems and buds 2½ lb. pkg.	15 lbs.	90
Brussel Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	30 lbs.	180
Spinach	Chopped, 2½ lb. pkg.	30 lbs.	180
Squash, Winter	3 lb. pkg.	15 lbs.	90
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

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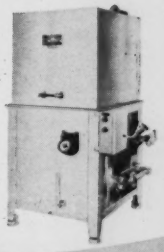
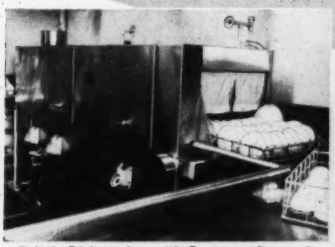
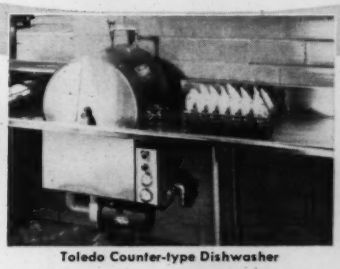
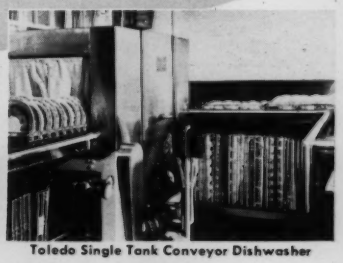




Toledo Dishwasher with Conveyor Prewash

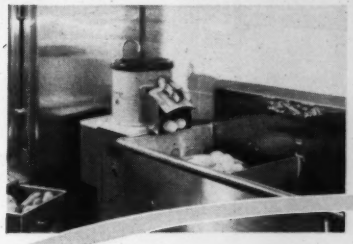


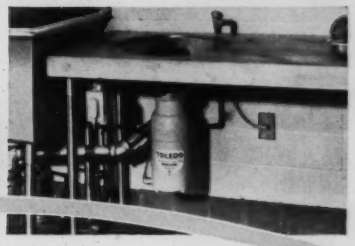
Toledo Counter-type Dishwasher



Toledo Single Tank Conveyor Dishwasher

Toledo Potato Peeler





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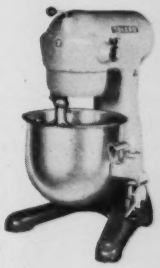

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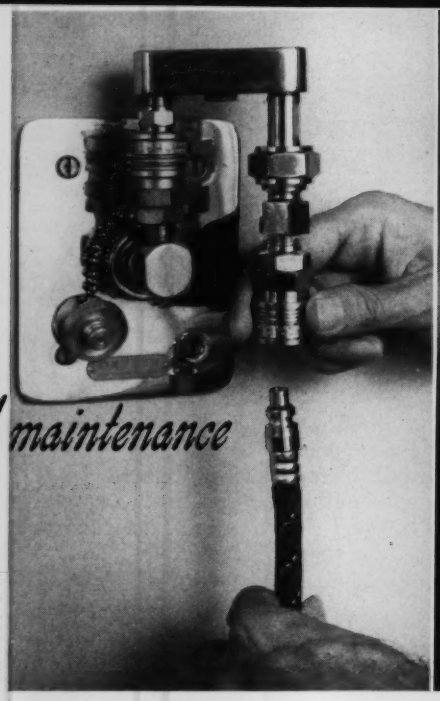

with two inexpensive devices . . .

we made oxygen administration safer

by COURTLAND E. CHANDLEE

AN OXYGEN tent fire might seem a remote possibility in these days of elaborate safety precautions —especially in newer hospitals. But a recent fire in a two-year-old hospital reminded us that fire can occur in new as well as old hospitals, and served as a warning to make a careful check of our own oxygen system.

Our hospital, a three-year-old structure, has piped oxygen to each room from a central source located in a separate building some 125 feet away from the hospital. From there, oxygen is carried to all parts of the hospital at a constant pressure of 50 pounds per square inch. Each room is equipped with an outlet having a bicycle-type valve without a hand control. This valve is released whenever the flexible tube from the oxygen tent is inserted.

Since the tent, when connected, releases the valve, and since the flowmeter is in the tent itself, the flexible tubing between the wall outlet and the tent is a weak link in the chain of safety. Any accident which would cause this flexible connection to be burned through or otherwise severed would immediately release oxygen at 50 pounds pressure into the room. In the presence of fire this could be a catastrophe.

SEVERAL METHODS EXPLORED

Several methods to correct this hazard were explored and discarded before the solution was hit upon. One of the best methods, an automatic check valve which would close if pressure in the line dropped suddenly, offered a complete solution. We found, however, that if they are to be used with oxygen, these valves must be specially made—at a higher cost than the standard item. This method would have been adopted if a simpler and cheaper one had not been found.

The method we chose appears to offer entirely adequate control. Using ready-made parts, some obtained from the manufacturer of our wall outlets, we constructed a flow limiting device to be attached between the wall valve and the tubing from the tent (see photograph). One end of this device is a standard male fitting that connects with the wall outlet. To this is coupled an "orifice plate" assembly that has been drilled to permit a maximum flow of 20 to 22 liters. At the other end of the assembly is attached a female fitting identical to that at the wall. This fitting is connected to the tubing from the tent.

We consider this device primarily a means for providing an extra measure of protection. It does not operate on any new principle; in fact, the parts for it are standard ones modified only to the extent of changing the metered hole in the "orifice plate" to provide a maximum flow of 20 to 22 liters. The "orifice plate" assembly is a standard commercial item. Although there are other commercial devices which might perform essentially the same function, ours

Courtland E. Chandlee is administrator of St. Clair Memorial Hospital, Pittsburgh.

is simple and can be fabricated locally at slight expense.

CONNECTIONS STANDARD

One of these assemblies is provided for each tent. When the tent is set up for use, the method of connecting it to the wall is the same as with the standard coupling. However, should the flexible tubing be severed, oxygen will flow into the room at a maximum rate of 22 liters instead of at 50 pounds pressure. The difference in volume between these two flows is dramatic and startling.

The 22-liter flow is considered adequate for all conditions, but if flushing of the tent is desired, the device can be removed while oxygen concentration is built up.

This arrangement is automatic and has no moving parts to fail at a critical moment. It is inexpensive, yet appears to offer adequate safety protection. The 22 liters of oxygen which would escape through the orifice should the tubing become disconnected should not provide any significant support to combustion in a room. Used with hall-located hand valves with which even this small flow can be stopped with a twist of a wrist, the device seems to complete the chain of protection, except for the basic hazard of carelessness on the part of patient or personnel.

The value of and need for this device in other hospitals would vary with the oxygen system and equipment in use. In our case it appears to offer a definite measure of protection. In other situations, where the flowmeter is connected at the wall and the valve of the flowmeter controls the oxygen before it reaches any flexible connection or breakable indicator gauge, there would seem to be no need for this device.

SECOND SAFETY MEASURE

A second safety precaution in the administration of oxygen is the placement of extinguishing apparatus where it is readily accessible in case of fire. Hanging an extinguisher on the tent is inadequate, for in the event of fire it may be impossible to reach. Standing an extinguisher on the floor in the corridor or in the room involves danger of upset and injury.

To overcome disadvantages of some other methods, we have designed an extinguisher rack which hooks over the door to the patient's room. (See photographs on page 92.) This rack is a board with a rubber covered metal hanger at the top to go over the door. The back of the board is covered with felt to prevent marring of the door. On the board is a hanger for a five-pound CO_2 fire extinguisher placed low enough so that it is within easy reach of the shortest nurse as she enters the room.

One of these racks is provided for each oxygen tent and is hung over the door whenever a tent is placed in use. It does not interfere with the swinging of the door except to prevent closing it the last inch or so.

On the rack above the extinguisher is a plastic sign which reads: "Oxygen — No Smoking". This sign, together with the extinguisher itself, reminds visitors of the danger from carelessness and smoking. ■

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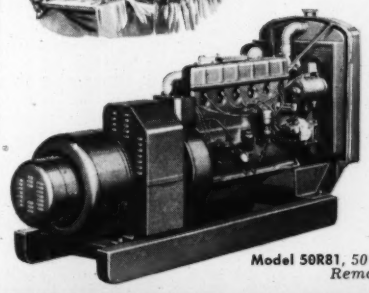

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film reviews

In this issue of the Journal, this space, which ordinarily carries book reviews, is devoted to a list of films reviewed and approved by the Film Review Board of the American Hospital Association.

Health Careers—(16 mm., black and white, sound, 14 min.) Produced by Wilding Picture Productions, Inc. Available from American Hospital Association.

This film is useful in demonstrating careers in the hospital field to high school, civic groups and vocational guidance classes.

Meeting in Session—(16 mm., black and white, sound, 20 min.) Available from Association Films, Inc., 561 Hillgrove, La Grange, Ill., 1953. Not cleared for television. Rental rate: $5.

A head nurse and her staff are depicted solving a problem incorrectly and correctly. The film gives an excellent recitation of how to train supervisors in problem solving, improving meetings, and group discussions. It requires additional direction by someone skilled in conference technique.

It is recommended for showing to staff, nursing groups and in leadership sessions.

No One Else Can Do It—Fact Finding Not Fault Finding—Foresight Not Hind Sight—What They Don't Know Can Hurt—(16 mm., black and white, series of four films, about 20 min. each.) Produced by Sara Productions. Sponsored by and available through the National Safety Council, 425 N. Michigan Ave., Chicago 11, 1955-1956. Rental: $10 a week. Purchase: $65 each. Not cleared for television.

These four films present an excellent illustration of planning, responsibility, displaying judgment, and training techniques.

They are designed for supervisors, foremen and leadership groups.

RX—A Prescription for Procedure—(16 mm., color, sound, 38 min.) Produced by Sears, Roebuck Department. Owner and available through the University of Illinois Research and Education Department, University of Illinois, 1853 W. Polk St., Chicago 23. Not cleared for television.

This is a film to stimulate hospitals to launch programs in work simplification and is recommended for showing to hospital personnel.

It's up to You—(16 mm., black and white, sound, 22 min.) Produced by Caravel Films, Inc., 730 Fifth Ave., New York 19. Sponsored by Associated Merchandising Corporation. Available on rental or purchase ($125) from Caravel Films. Not cleared for television.

This film is aimed at the development of supervisory and executive attitudes. It dramatizes a number of situations which are fundamental to good supervision, and gives examples of poor supervision: an employee criticized in the presence of others; a supervisor making promises she cannot keep; and an employee projected into a selling situation with sufficient instruction.

Recommended for executives and supervisors.

Hours To Live—(16 mm., color, sound, 26 min.). Produced by Al Kane Productions in 1956 for the Philadelphia Blue Cross in collaboration with the Pennsylvania Hospital. Available through Associated Hospital Service of Philadelphia, 112 South 16th Street, Philadelphia.

A dramatic presentation of the teamwork, skills, and techniques of modern medicine that lie behind the handling of an emergency case. The various facets of a well functioning hospital are vividly portrayed as we watch the re-enactment of a case as it actually happened. Excellent for professional and lay groups as a public relations tool in portraying the value of the Blue Cross Plan and a hospital's extensive services.

Know Your Fire Extinguishers—(16 mm., color, sound, 20 min.) Produced by Factory Mutual Engineering Division of Associated Factory Mutual Fire Insurance Company. Available from Associated Factory Mutual and Jackson Memorial Hospital, Miami 36, Fla., 1956, on loan or purchase. Not cleared for television.

The different fire extinguishers, their usage, effectiveness and results shown in this film is a valuable film to be included in all safety programs and shown also to civic groups and hospital personnel.

Supervisory Conferences—(16 mm., black and white, sound, 14 min.) Produced by Mc-Graw-Hill Productions. Available from Association Films Inc., 561 Hillgrove, La Grange, Ill., 1953. Rental: $5. Not cleared for television.

The purpose of this film is to explain the purpose of training programs and to stimulate favorable opinions toward them. It would be especially valuable to personnel directors, foremen and other supervisory personnel.

The Medical Witness—(16 mm., black and white, sound, 34 min.) Produced by William S. Merrell Company, in cooperation with the American Medical Association and the American Bar Association, 1956. Available from the American Medical Association, 535 N. Dearborn St., Chicago 10. Not cleared for television.

This film was the first in a series of six films intended to acquaint physicians with their responsibility in litigation and to dispel their fears of testifying in court. The film is also intended to aid attorneys in their working relationships with physicians and to impress upon them the necessity for adequate pretrial preparation and the use of proper demonstrative evidence.

Recommended audiences: medical staff and hospital personnel.

The Dedicated—(16 mm., color, sound, 27½ min.). Produced by William K. Chulack for the Catholic Hospital Association. Available on rental or purchase from the Catholic Hospital Association, St. Louis. Rental: $12.50. Purchase: $225.

"The Dedicated" traces the history of the Catholic hospital to its beginnings in early Christian times, through the era of great advances, emphasizing the importance of all of the personnel in the modern hospital.

It shows the departments of the modern hospital in operation and demonstrates how discoveries, re-

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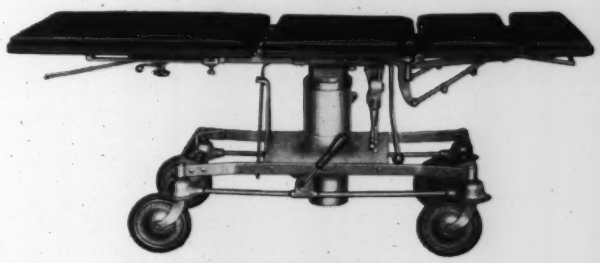
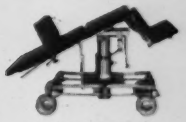


Model No. 25 without attachments
X-ray deep therapy treatment — Transporting accident room patients — Minor surgery



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cent and ancient, are utilized in the diagnosis and treatment of the patient.

Color and general presentation are excellent. Clubs, high school and college classes, and groups interested in and related to the hospital will find this film useful.

The Heart of a Community—(16 mm., color, sound, 25 min.). Produced by University of Mississippi Film Center for the Mississippi Hospital and Medical Service, and Coahoma County Hospital Auxiliary. Available on free loan for preview only from Mississippi Hospital and Medical Service, Jackson, Miss. Purchase: $200.

Five people from different walks of life are seen in their normal activities until each, in turn, has reason to come to the hospital. The audience follows each patient during his stay, seeing what must be done and the facilities and staff involved, in the patient's return to a healthy, useful life in his community. An effort was made to bring into focus the medical facilities and housekeeping functions, of which the general public is often unaware. A worthwhile film for civic and service clubs, high schools, hospital groups, medical groups and nurse recruitment, though the setting is a local one.

Home Care—(16 mm., black and white, sound, 28½ min.) Produced in 1955 by Benjamin Rosenthal Foundation of New York. Rental or purchase from Health and Welfare Materials Center, 10 East 44th Street, New York, N. Y. Rental: $10. Purchase: $50.

The role of the doctor, nurse and social worker—the members of the basic home care team—and the members of every other profession which participates in a home care program is described, as are the results of such care on a patient's physical and emotional well being.

The film was produced as a public service to stimulate discussion among hospital and other community leaders concerned with the problems of chronic disease and the best methods of providing care and treatment of patients with long term illness; however, continuity and patient testimonies are somewhat deficient. Recommended for professional and lay persons, and organizations interested in hospital programs and the care and treatment of patients with long term illness.

personnel changes

● ALVIN J. BINKERT has been appointed executive vice president of Presbyterian Hospital at the Columbia-Presbyterian Medical Center, New York City. Mr. Binkert has been vice president and general manager since September 1954. He has been with the hospital for 20 years.

MR. BINKERT

Mr. Binkert is responsible for the administration of all units of the hospital which is the largest voluntary hospital in the country.

Mr. Binkert is a member of the board of governors of the Greater New York Hospital Association and a trustee of the Hospital Association of New York State.

● W. BRUCE BOGGAN has been appointed administrator of Forsyth County Hospital, Cumming, Ga. He was formerly assistant to the director and purchasing agent of Macon (Ga.) Hospital.

Mr. Boggan is a graduate of the Georgia State College program in hospital administration.

● JOSEPH F. FARRELL has been appointed associate director of Germantown (Pa.) Dispensary and Hospital. Since 1948 Mr. Farrell has served as comptroller, and assistant director.

● BILL L. HAMILTON has been appointed assistant administrator of All Saints Episcopal Hospital, Fort Worth, Tex. He was formerly administrative assistant of the Methodist Hospital, Houston, Tex.

Mr. Hamilton is a graduate of the Washington University program in hospital administration.

MR. HAMILTON

MR. HENNESSEY

● THOMAS F. HENNESSEY has been appointed administrator of Springfield (Vt.) Hospital. He was formerly administrator of Parker Hill Medical Center, Boston.

● DANIEL I. KAHN has been appointed assistant administrator of Culver City (Calif.) Hospital. Mr. Kahn was formerly administrative assistant at the hospital.

● HOMER W. LOAR has been appointed assistant administrator of Children's Hospital, Cincinnati. He was formerly assistant administrator of Good Samaritan Hospital, Lexington, Ky.

● ROBERT W. LYONS has been appointed assistant administrative director of Cedars of Lebanon Hospital, Los Angeles. He was formerly administrator of Atchison (Kans.) Hospital.

MR. LYONS

He is a graduate of the Northwestern University program in hospital administration.

● WILLIAM A. MARKEY has been appointed administrator of the City of Hope Medical Center, Duarte, Calif. He was formerly assistant administrator of the hospital and succeeds SEYMOUR SCHULMAN.

Mr. Markey is a graduate of the Yale University program in hospital administration.

● JOHN D. MCCULLOUGH, M.D., has been appointed manager of the Veterans Administration Hospital, Northampton, Mass. He was formerly director of professional services at the Veterans Administration Hospital, Tuscaloosa, Ala.

Dr. McCullough succeeds RICHARD T. O'NEIL, M.D., who retired.

● JOSEPH D. MCGEE has been appointed assistant administrator of SS. Mary and Elizabeth Hospital, Louisville, Ky.

Mr. McGee recently completed a two year administrative residency

within the Louisville Medical Center, and has worked within the Children's Hospital, the Louisville General Hospital, the Waverly Hills Tuberculosis Sanatorium and particularly within the Jewish Hospital. He received his master of science degree in hospital administration from Northwestern University last month.

MR. McGEE

● EUGENE J. O'MEARA has peen appointed administrator of Sharon (Pa.) General Hospital, succeeding C. R. YOUNQUIST who has been appointed administrator of Shadyside Hospital, Pittsburgh.

Mr. O'Meara was formerly assistant superintendent of the Altoona (Pa.) Hospital. He is a graduate of the University of Chicago program in hospital administration.

● ERNEST M. TAPP, M.D., has been appointed manager of the Veterans Administration Hospital, Dearborn, Mich. He was formerly manager of the Veterans Administration Hospital, Poplar Bluff, Mo.

Dr. Tapp succeeds THOMAS P. CRANE, M.D., who was transferred to the Veterans Administration Hospital at San Francisco.

● ALBERT R. SARGENT has been appointed assistant director of Children's Hospital, Buffalo, N. Y. He previously held administrative posts at Meadowbrook Hospital and Nassau Hospital, both on Long Island.

He is a graduate of the Columbia University program in hospital administration.

MR. SARGENT

MR. WINHOLTZ

● HOWARD M. WINHOLTZ has been appointed assistant administrator of Rochester (Minn.) Methodist Hospital. Mr. Winholtz was formerly manager of the Worthington Clinic and prior to that was an associate professor in the department of business administration at Augsburg College, Minneapolis.

Mr. Winholtz is a graduate of the University of Minnesota program in hospital administration.

Deaths

● KATHARINE TUCKER died June 7 after a long illness. Her age was 72. Miss Tucker was a leader in public health nursing and nursing education.

From 1913 to 1916, she served as director of the social service department mental hygiene committee, New York State Charities Association. She was named general director of the Visiting Nurse Society of Philadelphia, 1916 to 1929.

She then was executive director of the National Organization for Public Health Nursing (now merged with the National League for Nursing). In 1935 she returned to Philadelphia as director of the department of nursing education at the University of Pennsylvania, and as professor of Public Health Nursing. Miss Tucker retired in 1949.

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THE LAW IN BRIEF

Legal matters of interest to the hospital field prepared by the law department of the American Hospital Association

Hospital wins bed rail case

Sarah H. Wills was admitted to the Emory University Hospital as a paying patient, suffering from pneumonia and in a semiconscious state. Side rails were attached to her bed to prevent her from falling—a full-length rail on one side and a half-length rail on the other side. Her pneumonia responded to treatment and she achieved a state of mental alertness. At that point it appears she fell out of bed and suffered a concussion; she died some weeks later. The husband brought suit against the hospital alleging that his wife was left unattended while in a semiconscious condition and that the hospital failed to secure her in her bed.

The Court of Appeals of Georgia held that it was incumbent upon the plaintiff to establish that his wife was semicomatose and under the influence of drugs at the time she was left unattended by the employees of the hospital and fell from her bed. The evidence indicated, the court stated, that on the night the deceased fell from her bed she was mentally alert, had conversed with her husband, and had given no indication that she could or would leave her bed. Thus the plaintiff failed to supply the necessary proof of semiconsciousness of the patient at the time of the fall.

Wills v. Emory University, 96 S.E. 2d 220 (Ga. App., 1956).

Electroshock therapy fractures

An English case tried in February 1957 and reported in the *British Medical Journal* illustrates the legal aspects of electroshock treatment of mental patients. The plaintiff, J. H. Bolam, had entered Friern Hospital in 1954 as a voluntary patient. He had a history of nervous debility and depression and had attempted to take his own life prior to entering the hospital.

In the absence of the consultant psychiatrist of the hospital, the senior registrar, Dr. Allfrey, administered electroshock therapy. Finding no indication for the need of a relaxant drug, the doctor rendered the treatment with no restraint other than control of shoulders and jaw, and a pillow under the back.

Mr. Bolam suffered a convulsion which shattered both hip bone sockets. He may never walk properly again. In his suit the plaintiff alleged that the treatment was negligently given because there was neither physical restraint nor use of a relaxant drug.

The plaintiff's medical witness stressed the absence of fractures when relaxants were employed, although admitting that relaxants were not as popular in 1954 as they are now, and that many physicians feel that neither relaxants nor extensive restraints are necessary.

A medical witness for the defense testified that he opposed use of relaxant drugs in electroshock therapy due to the mortality risk. He used these drugs only where the patient's life might otherwise be risked. At Friern Hospital there had been six fractures in 70,000 electroshock cases, however four deaths had resulted from use of relaxant drugs.

Even Dr. Allfrey was now using the drugs, he testified, because he has confidence in the newer products. There was evidence of the difference of opinion within the medical profession as to the desirability of using physical restraint, relaxant drugs, both, or neither, in shock treatment.

The judge advised the jury that a professional man was not guilty of negligence if he acted in accordance with a practice accepted by a competent group of skilled professionals, notwithstanding the existence of a body of opinion which took a contrary view; the jury must not judge 1954 circumstances by the knowledge of 1957.

The jury's verdict was for the defendants, the Friern Hospital Management Committee. The hospital and physician were not liable for injuries resulting from a course of treatment about which doctors engaged in the medical specialty have an honest difference of professional opinion.

Student nurse is an employee

Is a student nurse a "laborer" or "workman" under the workmen's compensation law which applies to charitable institutions? This was the question presented to the Supreme Judicial Court of Massachusetts for the first time in *Brewer's Case*, decided March 28, 1957, and answered affirmatively.

The fact that Alabama and Minnesota courts had interpreted their statutes to include student nurses under workmen's compensation was compelling. In addition, the Massachusetts court was impressed with these points:

- The student nurse was obliged to work regular shifts in addition to classroom hours.
- She was under the control and direction of hospital supervisory employees while on duty.
- She received compensation in the form of room and board.
- The work done by the student nurse was largely menial and manual and of the sort that would be done by a laborer or workman.

A student nurse who is an employee of the hospital for workmen's compensation purposes more than likely would be an employee for negligence purposes. If, in a given state, hospitals are not immune from suit in negligence actions, the negligence of a student nurse could result in the hospital's liability for her error.

In Massachusetts, charitable hospitals continue to enjoy immunity from suit for negligence of their employees. Miss Brewer's presence does not increase the hospital's potential liability towards patients and guests, but may increase the hospital's premium for workmen's compensation insurance.

This material is not legal advice. The information on this page should not be used to resolve legal problems. For advice on such problems a hospital should consult a member of the local bar.

Washington Report

Senate Approves $2.8 Billion for HEW

The Senate has approved an appropriation of more than $2.8 billion for the Department of Health, Education, and Welfare.

This is the first time in this session of Congress that the Senate has approved a major appropriations bill calling for a greater expenditure than the House had approved for the same program.

The Senate increase, $38 million more than that voted by the House, was allocated to the National Institutes of Health for medical research. Despite the increase, however, total HEW funds voted were still $66 million less than the administration had sought in its budget request.

Additional medical research funds approved by the Senate included more than $11 million for the National Cancer Institute, $4 million for mental health activities, $5 million for the National Heart Institute, $5 million for arthritis and metabolic disease activities, and $5 million for neurology and blindness research.

Included in the Senate appropriation was $121.2 million for the Hill-Burton program. This was the same figure voted by the House and approved by the Senate Appropriations Committee. The Hill-Burton figure is a reduction of $3.8 million from the 1957 appropriation and represents a cut confined entirely to projects under Part C, the basic Hill-Burton program.

As the bill now goes to a joint conference with the House, the Hill-Burton figure authorizes $99 million for the basic program and $21 million for the expanded program (chronic disease hospitals, rehabilitation centers, nursing homes, and diagnostic and treatment center projects). In addition, the Senate confirmed the House authorization of $1.2 million for research in hospital administration and operation.

The Senate also approved an amendment by Sen. Edward J. Thye (R-Minn.) to continue availability of funds for hospital survey and planning under Title VI of the Public Health Service Act. This amendment will make available survey and planning funds for two additional years. Congress had appropriated $2 million for this purpose, available for three fiscal years, but, as of April 30 only $907,000 had been used, leaving an unobligated balance of over $1 million. Sen. Thye's approved amendment will make these unobligated funds available for expenditure until June 30, 1959.

The increase of $38 million in federal funds for the National Institutes of Health, the Senate committee report stated, was accepted by both Democrats and Republicans as evidence of specific accomplishments during the past three years by NIH. The Senate committee report listed these accomplishments in three general areas:

- Specific applicable findings as indicated in individual institute reports have been forthcoming in all fields.
- Training of medical scientists has proceeded at an accelerated pace.
- Fundamental work, prerequisite to applied findings for the future, has proceeded at a satisfactory pace.

The committee report stated, and was further amplified in Senate debate on the HEW budget, that two general objectives were apparent in this unprecedented federal support for medical research. The first is that training for medical science should be further strengthened; and second, that medical research on massive problems generated by the major diseases should not be limited by lack of money.

The Senate also acted on a provision of the House bill by deleting a provision limiting the allowance for indirect costs on research grants to 15 per cent. In its report on this item, the Senate committee stated that indirect costs of research are as much a part of the total cost of research as are direct costs.

The report read in part: "This principle does not necessarily endorse the inclusion of all of the cost categories which witnesses have urged as being indirect costs. On this point, the committee expects to have the General Accounting Office conduct an extensive study of the proper categories of costs to be considered as indirect costs of research and to report to the committee by Jan. 1, 1958."

NIH was also directed by the committee to increase its indirect cost payments above the current level by a conservative amount, pending the outcome of the GAO study.

Following is a breakdown of the items in the Senate-passed HEW budget bill:

Indian Health Activities

1957 appropriation	$38,775,000
1958 budget estimate	43,990,000
House allowance	40,000,000
Senate recommendation	42,500,000

The Senate recommended an increase of $2.5 million over the House allowance, a reduction of $1,490,000 under the budget estimate, but an increase of $3,725,000 over the 1957 appropriation. This allowance provides funds to meet the mandatory items amounting to $1,786,000 and will provide $939,000 for new program items, including $100,000 for the practical nurse school expansion.

Construction of Indian Health Facilities

1957 appropriation	$8,762,000
1958 budget estimate	5,800,000
House allowance	3,096,000
Senate recommendation	3,096,000

The Senate approved the House allowance, a reduction of $2,704,000 from the budget request and a reduction of $5,666,000 from the 1957 appropriation.

General Research and Services, National Institutes of Health

1957 appropriation	$12,122,000
1958 budget estimate	14,026,000
House allowance	14,026,000
Senate recommendation	14,026,000

The Senate recommended an appropriation of $14,026,000, the amount of the House allowance and the budget estimate. This appropriation item covers two groups of activities. The first group consists of research grants, fellowships, and training activities which provide an essential supplement to

the disease-based programs of the seven institutes. The second group consists of the operation of the direct research activities of the National Institutes of Health in Bethesda, Md., and elsewhere.

National Cancer Institute

1957 appropriation	$48,432,000
1958 budget estimate	46,902,000
House allowance	46,902,000
Senate recommendation	58,543,000

The Senate recommended $58,543,000 for activities under this appropriation, an increase of $11,641,000 over the House allowance and the budget estimate.

Mental Health Activities

1957 appropriation	$35,197,000
1958 budget estimate	35,217,000
House allowance	35,217,000
Senate recommendation	39,421,000

National Heart Institute

1957 appropriation	$33,396,000
1958 budget estimate	33,436,000
House allowance	33,436,000
Senate recommendation	38,784,000

Dental Health Activities

1957 appropriation	$6,026,000
1958 budget estimate	6,430,000
House allowance	6,430,000
Senate recommendation	6,430,000

Arthritis and Metabolic Disease Activities

1957 appropriation	$15,885,000
1958 budget estimate	17,885,000
House allowance	17,885,000
Senate recommendation	23,548,000

Allergy and Infectious Disease Activities

1957 appropriation	$13,299,000
1958 budget estimate	17,400,000
House allowance	17,400,000
Senate recommendation	17,400,000

Neurology and Blindness Activities

1957 appropriations	$18,650,000
1958 budget estimate	18,887,000
House allowance	18,887,000
Senate recommendation	24,058,000

Grants for Construction of Health Research Facilities

1957 appropriations	$30,000,000
1958 budget estimate	30,000,000
House allowance	30,000,000
Senate recommendation	30,000,000

National Library of Medicine

1957 appropriation	$1,314,767
1958 budget estimate	1,450,000
House allowance	1,450,000
Senate recommendation	1,450,000

The budget estimate was approved to provide for the operating expenses of the National Library of Medicine in the Public Health Service.

Grants to States for Public Assistance

1957 appropriation	$1,575,000,000
1958 budget estimate	1,679,400,000
House allowance	1,600,000,000
Senate recommendation	1,600,000,000

The Senate approved the House allowance, a reduction of $79.4 million from the budget estimate, but $25 million over the 1957 appropriation. The Senate recommended the striking out of the limitation on the amount of funds to be made available for expenses of state and local administration.

PUBLIC ASSISTANCE AMENDMENTS

The American Hospital Association has urged Congress to take immediate and favorable action on a bill introduced by Rep. John W. McCormack (D-Mass.); this bill would revise the formula for federal-state matching of expenditures for medical care vendor payments under the Social Security Act. The payment program goes into effect July 1.

In a special statement to Sen. Harry F. Byrd (D-Va.), chairman of the Senate Finance Committee

REP. McCORMACK

SEN. BYRD

which is considering the McCormack bill, AHA's Washington Service Bureau asked that Senate action be taken to remove unintended results of the 1956 public assistance social security amendments which would create hardship conditions in a number of states.

The Association, in a prepared statement, pointed out that administrative agencies of certain states have discovered that they would not be justified in making the financial sacrifice in maintaining vendor payment programs as they have in the past, in keeping with the 1956 public assistance medical care amendments. The effect of the 1956 amendments in these states would apparently lessen rather than increase the use of the vendor payment method.

Kenneth Williamson, director of the Washington Service Bureau, pointed out in his statement to Sen. Byrd's committee that "in the opinion of the American Hospital Association, departure from this method of payment will have unfortunate consequences for our nation's hospitals. . . We urge your immediate consideration and favorable action on HR 7238."

The McCormack bill was introduced on May 6 by Rep. McCormack, House majority leader, to correct the unintended result of causing financial loss in several states in their medical care vendor payment programs. The bill was unanimously passed by the House on June 3 and is now before the Senate Finance Committee for hearings in executive session.

The McCormack bill insures that no state will incur financial losses in its vendor payment programs by permitting states to determine federal participation in any one of the following three ways:

1. Under the 1950 formula, or as the states are now doing.
2. Under the formula proposed in the 1956 amendments.
3. Under a combination of the 1950 and 1956 formulas.

'MEDICARE' STATEMENTS

The American Hospital Association's— The American Hospital Association's concern over a recent report of the House Appropriations Committee on the "medicare" program was put before the Senate Committee on Appropriations in a special statement by the Washington Service Bureau.

In a letter to Sen. Carl Hayden (D-Ariz.), chairman of the Senate Committee on Appropriations, Mr. Williamson stated: "We believe that the committee's recommendation which would revise the 'free choice' element is not in the best interests of the dependents, nor of the country at large; and, in fact, the elimination of 'free choice' would wreck the program. This issue of 'free choice' was thoroughly explored by the committees of the Congress which conducted the hearings on the basic legislation."

Mr. Williamson pointed out that in contrast to the language of the House Appropriations Committee report, what Rep. Paul J. Kilday (D-Tex.), subcommittee chairman of the House Armed Services Committee, had said when the defense department appropriation bill for 1958 was being debated, was: "I hope we will continue with this program to see what history will develop. . . I believe we are on the right track. I believe the privilege of free choice should be continued and that we should not follow the recommendation as set forth in the Appropriations Committee report at this particular time."

In its statement the AHA stated that it continues to support the Dependents' Medical Care Act in its present form and urged that ". . . the Senate Appropriations Committee appropriate the sums

necessary to continue this program preserving for military dependents their right of freedom of choice."

"Medicare" Officials'—Officials supervising the armed forces Dependents' Medical Care Act ("medicare") challenged statistics brought forth to strengthen a House committee view that "medicare" dependents should not use civilian hospitals where military facilities are adequate.

This Defense Department action supports an AHA statement to Congress that it is "premature" to suggest that federal funds would be saved by restricting dependents' "free choice" of civilian or military hospitals.

"Medicare" director, Maj. Gen. Paul I. Robinson, reported on the statistics in issue to a Senate subcommittee considering defense department appropriations for fiscal 1958. Gen. Robinson said the Bureau of the Budget made a cursory survey last winter which showed that civilian medical facilities cost "medicare" $34.50 per day. Another bureau report a month later gave a cost of approximately $65 per day, he said.

The Defense Department had reported earlier that hospital care alone was costing "medicare" between $18 and $20 per day.

The "medicare" director agreed with Sen. Leverett Saltonstall (R-Mass.) that "one of the fundamental backgrounds" of the "medicare" act would be jeopardized by any change in the "free choice" provision.

In testimony before another Senate committee, Maj. Gen. Silas B. Hays, surgeon general of the Army, said the cost of "medicare" was running about $5 million per month, approximately the figure estimated when the law was enacted a year ago.

Gen. Hays said that aside from obstetrical care, the first six months of "medicare" operation has not altered the overall load on military medical facilities. While there has been a slight increase in the use of military facilities overseas, there has been a corresponding reduction, approximately 5 per cent, in the inpatient cases within the United States.

New York Court Reverses Hospital Immunity Rulings

New York State's highest court, the Court of Appeals, has reversed the precedent in that state which gave hospitals limited immunity from negligence suits and has held that hospitals are liable in the same manner as ordinary business corporations.

The ruling was in the case of Bing v. Thunig, May 16, 1957.

In the court's opinion, stated Justice Stanley Fuld. "The rule of nonliability is out of time with life around us, at variance with modern day needs, and with concepts of justice and fair dealing. It should be discarded."

Justice Fuld concluded that hospitals should shoulder the same responsibility borne by others and that there was no reason to continue their exemption from the rule of *respondeat superior* (let the master answer for his servant's deeds).

Mid-West Association Names Barber Full-time Secretary

Margaret S. Barber, Kansas City, Mo., has been named full-time executive secretary of the seven-state Mid-West Hospital Association, it was recently announced by the hospital group's executive committee.

For the past two years Mrs. Barber has served as part-time administrative assistant at Bethany Hospital, Kansas City, Kans., and

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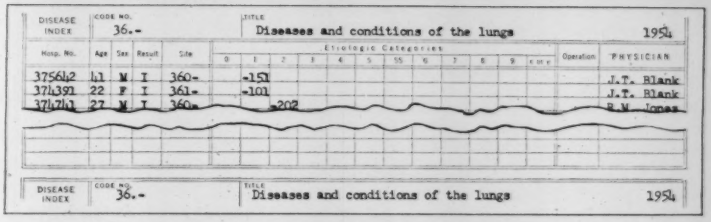

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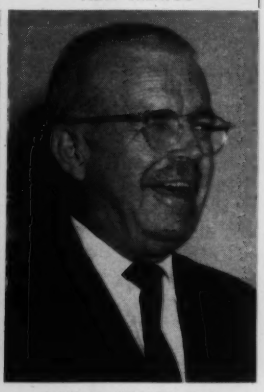

ROY H. TURLEY, D.D.
Superintendent
Espanola Hospital
Espanola
(50 beds)

part-time executive secretary of the association.

Mrs. Barber holds a bachelor's degree in nursing; she also has a master's degree in hospital administration from St. Louis University and spent a year's residency in hospital administration at Bethany before becoming administrative assistant there.

This marks the first time the hospital group has employed a full-time executive secretary in several years, according to Bryce L. Twitty, Tulsa, Okla., president of the 800 hospital organization.

The association includes the states of Arkansas, Colorado, Kansas, Missouri, Nebraska, Oklahoma, and Wyoming.

Georgia Hospital Group Names Executive Secretary

Glenn M. Hogan has been named executive secretary of the Georgia Hospital Association. Mr. Hogan assumed his new post on May 13 in the association's new headquarters, Room G, 2025 Peachtree Road, N.E., Atlanta 9.

MR. HOGAN

Mr. Hogan, a graduate of the School of Public Affairs of Emory University, is a former assistant administrator of Emory University Hospital, Atlanta.

Personnel Shortage Cited By Sage at X-ray Convention

A solution to the shortage of qualified technical personnel was one of the problems cited as requiring the attention of the Second International Convention of X-ray Technicians which met June 8-13 in Washington, D. C.

Mention of the shortage was made by David C. Sage, R.T., in his presidential address at the con-

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vention's opening session. He said that these problems also merited the convention's attention:

- The need for improved educational and teaching standards.
- The need for leadership and leaders in directing the efforts of x-ray technologists into proper channels.
- The formation of a permanent international society of x-ray technicians.

In another address, John F. Weale, R.T., stressed the importance and value of employing qualified x-ray technicians in reducing the hazards of excessive radiation. He said that those who are not properly qualified to perform their duties can do considerable harm by exposing patients to excessive amounts of radiation in an attempt to produce diagnostic x-rays.

George F. Koenig, R.T., chief technician at the University of Missouri Hospital, Columbia, Mo., was named the first place winner in the X-ray Section of the National Electrical Manufacturers' Association judging. The award is made for the outstanding scientific paper presented at the annual meeting of the American Society of X-ray Technicians.

Pan-Pacific Congress Set

The Seventh Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, Nov. 14-22. A hospital institute will be held as an integral part of the congress. Further information and brochures may be obtained by writing to Dr. F. J. Pinkerton, director general, Pan-Pacific Surgical Association, Suite 230, Alexander Young Building, Honolulu.

Nursing Home Ceiling Falls

Six persons narrowly escaped injury June 10 when a ceiling collapsed in the main lobby of St. Ann's Home for the Aged, Hammond, Ind.

No reason could be found immediately for the collapse of the ceiling which measures 75 by 40 feet. Both the plaster and wood lath tore away from the beams of the two-story building, which was constructed in 1918.

The home is operated by the Sisters of Mercy.

Hospital Administration Appointment Made by Navy

Cmdr. L. J. Elsasser, Navy medical corps, has been assigned to the Bureau of Medicine and Surgery as director of the Hospital Administration Division. Hospital administration is a new division within the bureau. It was recently established to develop, evaluate, coordinate, and advise on the business management and nonprofessional administrative needs of naval hospitals and other naval medical activities, the Navy stated.

Appoint Assistant Professor

Daniel L. Drosness has been appointed assistant professor of hospital administration, Program in Medical and Hospital Administration, Graduate School of Public Health, University of Pittsburgh. Mr. Drosness, who holds a master's degree in public health from the university, has served with the Health Insurance Plan of Greater New York and with the Public Health Service.

MR. DROSNESS

QUIK QUIZ

1. How many ways have you used RLP Pure Latex Tubing?

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the 1957 administrative residents

Presented here are some of the 1957 administrative residents who have completed their class work and are now beginning their internships at hospitals throughout the country. Residents not shown here will appear in the July 16 issue.

BAYLOR UNIVERSITY WITH MEDICAL FIELD SERVICE SCHOOL

Course director: Col. William A. Hamrick

AHR, LT. COL. LEE A., to Panama.

ARCHER, LT. COL. HARVEY E., to Fort Bragg, N. C.

BARNEY, MAJ. LEONARD C., to Germany.

BAUMAN, CAPT. BERNARD F., to Wright-Patterson Air Force Base, Dayton, Ohio.

BRANDT, LT. COL. JEROME N., to Fort Benjamin Harrison, Ind.

BURNIE, MAJ. HARRISON G., to Gunter Air Force Base, Montgomery, Ala.

BURNS, LT. COL. JOHN E., to Brooke Army Hospital, Fort Sam Houston, Tex.

BURROWS, MAJ. MARY L., to Germany.

CONNELL, CAPT. WILLIAM F., to Canada.

CREWS, 1ST LT. JAMES M. JR., to Maxwell Air Force Base, Montgomery, Ala.

DEGRAFF, MAJ. GEORGE J., to Headquarters First Army, Governor's Island, N.Y.

DIEDRICH, CAPT. FREDERICK J. JR., to Maxwell Air Force Base, Montgomery, Ala.

DROTNING, CAPT. THEODORE B., to Office of the Surgeon General, Washington, D.C.

ENGLISH, MAJ. ROBERT L., to Gunter Air Force Base, Montgomery, Ala.

GARGUREVICH, MAJ. ENRIQUE G., to Peru.

GOTT, LT. COL. WILLIAM E., to Army Advisory Group, Kearny, N. J.

GRIMES, CAPT. IVAN B., to Bryan (Tex.) Air Force Base.

KEGERREIS, LT. COL. JOHN B., to Fort Devens, Mass.

KERCHNER, CAPT. CHALMERS F., to Manhattan Beach, Brooklyn, N.Y.

KLAINER, CAPT. CECELIA T., to Fort Ord, Calif.

HADLEY, 1ST LT. NEIL B., to Wright-Patterson Air Force Base, Dayton, Ohio.

HOBSON, MAJ. ROBERT W., to Larson Air Force Base, Moses Lake, Wash.

HOGAN, MAJ. ANNE E., to Germany.

HOLBROOK, CAPT. ROBERT W. to Germany.

HOLT, MAJ. JOHN W., to Japan.

HOOPER, 1ST LT. HALBERT J., to Maxwell Air Force Base, Montgomery, Ala.

JAMES, LT. COL. WILLARD W., to Fort Hood, Tex.

LAUGHLIN, MAJ. THOMAS JR., to Japan.

LINTHICUM, LT. COL. SETH H. JR., to Brooke Army Hospital, Fort Sam Houston, Tex.

LOEBIG, MAJ. GORDON F., to Parks Air Force Base, Pleasanton, Calif.

LUEHRS, MAJ. WILLIAM C., to Fort Gordon, Ga.

MARSALA, LT. COL. ANTHONY J., to Brooke Army Medical Center, Fort Sam Houston, Tex.

MARSH, LT. COL. EDWIN S., to Germany.

MCINTYRE, LT. COL. EDWARD J., to Brooke Army Hospital, Fort Sam Houston, Tex.

MONNEN, LT. COL. MILLARD C., to Office of the Surgeon General, Washington, D. C.

MOORE, LT. COL. ARLICE J., to Fort George C. Meade, Md.

NAQI, LT. COL. MOHAMMAND, to Pakistan.

NICHOLSON, MAJ. GUY C., to Wright-Patterson Air Force Base, Dayton, Ohio.

BAYLOR UNIVERSITY WITH MEDICAL FIELD SERVICE SCHOOL residents are, (from left) front row: Lt. Col. Anthony J. Marsala; Maj. Enrique G. Gargurevich (Peru); Col. Wongse-Sanit Patana (Thailand); Capt. Cecelia T. Klainer; Maj. Alice E. Weinstein; Col. William A. Hamrick (director, Department of Administration); Brig. Gen. Elbert DeCoursey (commandant, Army Medical Service School); Lt. Col. Sam A. Edwards (assistant director, Department of Administration); Maj. Mary L. Burrows; Maj. Ann E. Hogan; Lt. Col. Cho Yung Sun (Korea); Lt. Col. John B. Kegerreis. Second row: Maj. Bernard A. Hart; Lt. Col. Lee A. Ahr; Lt. Col. Willard W. James; Maj. Joseph H. Wallace; Capt. William F. Connell (Canada); Maj. Rees F. Schaller; Lt. Col. Arlice J. Moore; 1st Lt. Neil B. Hadley; Lt. Col. Harvey E. Archer; Lt. Col. Millard C. Monnen; Lt. Col. Martin Putnoi; Maj. Howard F. Vire; Col. Chang Ting Tso (Taiwan); Maj. Bernard Rapparport; Lt. Col. Edward J. McIntyre; Maj. Guy C. Nicholson; Maj. John W. Holt. Third row: Lt. Col. William E. Gott; Capt. Theodore B. Drotning; Capt. Ivan B. Grimes; Lt. Col. Foster L. Watts; Maj. Ross F. Swall; Col. Esfendiar Soleymanloo (Iran); Lt. Col. John E. Burns; Maj. Leonard C. Barney; Lt. Col. Mohammand Nagi (Pakistan); Maj. Harrison G. Burnie; Maj. Robert W. Hobson; Maj. Robert L. English; Capt. Chalmers F. Kerchner; Maj. William C. Luehrs; Lt. Col. Seth H. Linthicum Jr.; Lt. Col. Martin A. Verzi. Fourth row: 1st Lt. Halbert J. Hooper; Maj. James H. Snelling; 1st Lt. James M. Crews Jr.; Maj. Thomas Laughlin Jr.; Maj. Walter F. Robbins; Capt. Kenneth W. Peters; Maj. Gordon F. Loebig; Lt. Col. Edwin S. Marsh; Capt. Bernard F. Bauman, Maj. Charles J. Werderman; Capt. Frederick J. Diedrich Jr.; Lt. Col. Jerome N. Brandt; Lt. Col. John B. Plum; Maj. George J. DeGraff; Capt. Robert W. Holbrook, and Maj. Felix G. Rajecki.

PATANA, COL. WONGSE-SANIT, to Thailand.

PETERS, CAPT. KENNETH W., to Altus (Okla.) Air Force Base.

PLUM, LT. COL. JOHN B., to Japan.

PUTNOI, LT. COL. MARTIN, to Fort Jay, N.Y.

RAJECKI, MAJ. FELIX G., to Germany.

RAPPARPORT, MAJ. BERNARD, to Fort Lee, Va.

ROBBINS, MAJ. WALTER F., to Fort Knox, Ky.

SCHALLER, MAJ. REES F., to Valley Forge Army Hospital, Phoenixville, Pa.

SNELLING, MAJ. JAMES H., to Fort Huachuca, Ariz.

SOLEYMANLOO, COL. ESFENDIA R., to Iran.

SUN, LT. COL. CHO YUNG, to Korea.

SWALL, MAJ. ROSS F., to France.

TSO, COL. CHANG TING, to Formosa.

VERZI, LT. COL. MARTIN A., to France.

VIRE, MAJ. HOWARD F., to Carlisle Barracks, Pa.

WALLACE, MAJ. JOSEPH H., to Ellington Air Force Base, Houston, Tex.

WATTS, LT. COL. FOSTER L., to Fort Ord, Calif.

WEINSTEIN, MAJ. ALICE E., to Tripler Army Hospital, Hawaii.

WERDERMAN, MAJ. CHARLES J., to Randolph Air Force Base, San Antonio, Tex.

UNIVERSITY OF CHICAGO

Course director: Ray E. Brown

BERGKVIST, CARL I., to Robert Wallace, superintendent, Dixon (Ill.) State Hospital.

BOYLE, JERRY B., to Stanley A. Ferguson, superintendent, University Hospitals, Cleveland.

DUNNING, DR. RICHARD G., to Dr. G. Otis Whitecotton, medical director, Alameda County Hospital System, Oakland, Calif.

ENNIS, WILLIAM H., will return to active administration.

FOWLER, WILLIAM J., to Albert H. Scheidt, administrator, Dallas (Tex.) City-County Hospital system.

FOX, EVERETT V., will return as administrator, Kate Bittings Reynolds Hospital, Winston-Salem, N. C.

DA GAMA E SILVA, DR. MATHIAS, to Dr. Peter A. Volpe, administrator, Ohio State University Hospitals, Columbus.

HATFIELD, DAVID M., to Ray E. Brown, superintendent, University of Chicago Clinics, Chicago.

HUTCHINSON, PETER S., to Donald W. Cordes, administrator, Iowa Methodist Hospital, Des Moines.

PETRING, MARSHAL C., to Alexander Harmon, superintendent, Cleveland (Ohio) City Hospital.

SABICHI, FRANCISCO D., to Edmund J. Shea, administrator, University of Indiana Medical Center, Indianapolis.

STRICKER, JAMES R., to Dr. Karl S. Klicka, director, Presbyterian-St. Luke's Hospital, Chicago.

COLUMBIA UNIVERSITY

Course director: Dr. E. Dwight Barnett

ADAMEC, KENNETH, to Dr. A. P. Merrill, superintendent, St. Barnabas Hospital, Bronx, N. Y.

BENABE, JOSE, to Agustin Diaz, executive administrator, Bayamon (P. R.) District Hospital and to Dr. Jaime Serra-Chavarry, manager, San Patricio Hospital, San Juan, P. R.

BOSTIN, MARVIN, to Dr. Eugene D. Rosenfeld, executive director, Long Island Jewish Hospital, New Hyde Park, N. Y.

UNIVERSITY OF CHICAGO residents are, (from left) front row: Dr. Mathias da Gama e Silva; William H. Ennis; Carl I. Bergkvist. Second row: Francisco D. Sabichi; William J. Fowler; Dr. Richard D. Dunning; David M. Hatfield. Third row: James R. Stricker; Marshall C. Petring; Jerry B. Boyle; Everett V. Fox. Fourth row: Vernon W. Forsman (associate course director); So V. Zimmermann (coordinator of the program), and Ray E. Brown (director of the program). Not shown: Peter S. Hutchinson.

CHAPPELL, JOHN, to Alfred E. Maffly, administrator, Herrick Memorial Hospital, Berkeley, Calif.

CURRIER, LLOYD, to A. W. Eckert, director, Perth Amboy (N.J.) General Hospital.

FREIWIRTH, MARTIN, to Dr. Martin Cherkasky, director, Montefiore Hospital, Bronx, N. Y.

GRANT, THOMAS W., to Martin S. Ulan, administrator, Hackensack (N.J.) Hospital.

GREENFIELD, RICHARD, to Carl F. Demo, administrator, St. Luke's Hospital, Newburgh, N. Y.

HINES, JOSEPH, to Harry C. F. Gifford, administrator, Community Hospital at Glen Cove (N.Y.).

HONKANEN, CLARENCE, to George E. Cartmill Jr., director, Harper Hospital, Detroit.

HOOD, JAMES, to Howard R. Taylor, director, Niagara Falls (N.Y.) Memorial Hospital.

JOEL, WILLIAM, to John H. Beddow, director, Middlesex General Hospital, New Brunswick, N. J.

LANGE, MANFRED, to Dr. Lloyd H. Gaston, director, St. Luke's Hospital, New York City.

LANGEVIN, HENRY, to Dr. Edward Kirsch, executive director, Lebanon Hospital, Bronx, N. Y.

LAUTERSTEIN, RONALD, to A. Rosenberg, executive director, Hospital for Joint Diseases, New York City.

LOVEJOY, ROBERT, to R. Ashton Smith, director, Lawrence (Mass.) General Hospital.

MCBETH, MAX, to William K. Klein, director, Long Island College Hospital, Brooklyn, N. Y.

MCTERNAN, EDMUND, to Frank Sauer, director, Muhlenberg Hospital, Plainfield, N. J.

MALONE, ARTHUR, to Dr. Endre K. Brunner, manager, Veterans Administration Hospital, Bronx, N. Y.

MARKOWITZ, ROBERT, to Dr. Martin R. Steinberg, director, Mt. Sinai Hospital, New York City.

MAZEN, DR. AHMED, to Dr. Martin Cherkasky, director, Montefiore Hospital, Bronx, N. Y.

MEDALLIS, LEON, to Dr. Kermit H. Gates, director, Jackson Memorial Hospital, Miami, Fla.

MIRABITO, JOHN, to Nelson O. Lindley, administrator, Somerset Hospital, Somerville, N. J.

PELTZIE, KENNETH, to Dr. Julien Priver, director, Sinai Hospital, Detroit.

SHUCKEROW, JOSEPH, to Dr. Lloyd H. Gaston, director, St. Luke's Hospital, New York City.

SLOANE, ROBERT M., to Dr. Reo J. Marcotte, director, Mt. Auburn Hospital, Cambridge, Mass.

UNIVERSITY OF MICHIGAN residents are, (from left) front row: D. Finch; W. Atkinson; B. Zimmerman; Sister M. Francis Xavier; J. Ensign; R. Boardman; J. Sullivan. Second row: E. J. Connors (instructor in hospital administration); J. Russell; W. Hufton; H. Morris; W. Schmidt; J. Gartland; D. Schmaus; J. Kamatoy, and Walter J. McNerney (director of program).

SMITH, LOWELL W., to John A. Dare, administrator, Virginia Mason Hospital, Seattle.

SNYDER, DONALD, to John W. Cavers, administrator, Wesson Memorial Hospital, Springfield, Mass.

SWEET, JOSEPH, to Dr. George Graham, director, Ellis Hospital, Schenectady, N. Y.

WATHNE, CARL, to Harvey Schoenfeld, director, Nathan and Miriam Barnert Memorial Hospital, Paterson, N. J.

WOLINSKY, EUGENE, to Dr. John L. Wilson, medical officer in charge, Public Health Service Hospital, Stapleton, N. Y.

UNIVERSITY OF MICHIGAN

Course director: Walter J. McNerney

ATKINSON, WILLIAM S., to Ronald Yaw, director, Blodgett Memorial Hospital, Grand Rapids, Mich.

BOARDMAN, ROBERT C., to William S. Brines, director, Newton-Wellesley Hospital, Newton Lower Falls, Mass.

ENSIGN, JAMES M., to Dr. Robin Buerki, executive director, Henry Ford Hospital, Detroit.

FINCH, DANIEL N., to J. G. Montgomery, administrator, St. Luke's Hospital, Toledo, Ohio.

GARTLAND, JOHN E., to Dr. A. C. Kerlikowske, director, University Hospital, Ann Arbor, Mich.

HUFTON, WILFRID L., to Franklin P. Iams, administrator, New York University-Bellevue Medical Center, New York City.

KAMATOY, JOSE T., special student from the Philippines.

MORRIS, HENRY J., to Dr. Roger W. DeBusk, director, Grace Hospital, Detroit.

RUSSELL, JOHN A., to John M. Danielson, administrator, Evanston (Ill.) Hospital.

SCHMAUS, DONALD M., to Dr. H. M. Coon, administrator, Milwaukee (Wis.) County Hospital.

SCHMIDT, WILLIAM S., to Dr. Albert W. Snoke, director, Grace-New Haven (Conn.) Community Hospital.

SULLIVAN, JAMES, graduating class of 1957.

ZIMMERMAN, BERTRAM, to R. R. Griffith, director, Delaware Hospital, Wilmington.

XAVIER, SISTER M. FRANCIS, to Mother Mary Nicholas, Provincial House, Detroit.

UNIVERSITY OF MINNESOTA

Course director: James A. Hamilton

BAKKEN, ROBERT L., to Richard M. Trenkner, administrator, Memorial Hospital of South Bend (Ind.)

BOOTH, GEORGE M., to Marie J. Doud, administrator, Highland Hospital, Rochester, N. Y.

BUSHMAN, WESLEY E., to Carl C. Lamley, executive director, Stormont-Vail Hospital, Topeka, Kans.

DAMBERG, DAVID V., to O. G. Pratt, executive director, Rhode Island Hospital, Providence.

DETMER, LAWRENCE M., to Dr. Russell O. Nelson, director, Johns Hopkins Hospital, Baltimore.

HOOD, MALCOLM W., to David E. Olsson, administrator, San Jose (Calif.) Hospital.

JOHNSON, WILLIAM E. JR., to Raymond K. Swanson, superintendent, Swedish Hospital, Minneapolis.

KRISMER, JOHN R., to William N. Wallace, administrator, Chas. T. Miller Hospital, St. Paul.

LARSON, C. ROBERT, to R. W. Bachmeyer, director, St. Barnabas Hospital, Minneapolis.

MCPHEE, LT. JACK C., to Maj. Maybell, associate professor of hospital administration, Baylor University, 3700th USAF Hospital, Lackland Air Force Base, Tex.

MANNING, IAN F., to L. N. Hickernell, director, Vancouver (British Columbia) General Hospital.

MANUEL, RICHARDS M., to Merton E. Knisely, administrator, St. Luke's Hospital, Milwaukee.

MARSH, VIRGIL W., to Donald F. Smith, superintendent, Minneapolis (Minn.) General Hospital.

NELSON, EDMUND K., to Kenneth Holmquist, superintendent, Bethesda Hospital, St. Paul.

PALMQUIST, LOWELL E., to Carl N. Platou, administrator, Fairview Hospital, Minneapolis.

PETERSON, A. KENNETH, to Dr. B. W. Mandelstam, administrator, Mt. Sinai Hospital, Minneapolis.

UNIVERSITY OF MINNESOTA residents are, (from left) front row: Capt. LeRoy D. Werley Jr.; Inkeri Vauraste; Ruth H. Inghram, (course instructor); James W. Stephan (associate course director); Dr. Gaylord W. Anderson (director, School of Public Health); James A. Hamilton (course director); Edith M. Lentz (assistant professor); Sister Mary Madonna; Lt. Jack McPhee. Second row: Ian F. Manning; Robert L. Bakken; Reginald A. Spindler; A. Kenneth Peterson; George M. Booth; James C. Ware; Joel T. Watson; Robert D. Strathy; William E. Johnson Jr.; Raymond J. Schumacher; Lowell E. Palmquist. Third row: David V. Damberg; C. Robert Larson; Edmund K. Nelson; John R. Krismer; Lawrence M. Detmer; Richards M. Manuel; Wesley E. Bushman; Malcolm W. Hood; Lowell M. Vandervort, and Virgil W. Marsh.

SCHUMACHER, RAYMOND J., to Miriam Curtis, R.N., administrator, Syracuse (N.Y.) Memorial Hospital.

SISTER MARY MADONNA, to Ray M. Amberg, director, University of Minnesota Hospital, Minneapolis.

SPINDLER, REGINALD A., to Harold C. Mickey, administrator, Rochester (Minn.) Methodist Hospital.

STRATHY, ROBERT D., to Frank R. Briggs, administrator, Abbott Hospital, Minneapolis.

VANDERVORT, LOWELL M., to Boone Powell, director, Baylor University Hospitals, Dallas, Tex.

WARE, JAMES C., to Frank S. Groner, director, Baptist Memorial Hospital, Memphis, Tenn.

WATSON, JOEL T., to Milo Anderson, administrator, Strong Memorial Hospital, Rochester, N. Y.

WERLEY, CAPT. LEROY D. JR., to Maj. Maybell, associate professor of hospital administration, Baylor University, 3700th USAF Hospital, Lackland Air Force Base, Tex.

NAVAL SCHOOL OF HOSPITAL ADMINISTRATION

School commanding officer:
Comdr. C. F. Crawford

ADAMS, LT. (JG) CHAUNCEY C. JR., MSC, USN.

BENDER, LT. URBAN J., MSC, USN.

BERGQUIST, LT. MELVIN D. JR., MSC, USN.

BEYER, LT. (JG) CHARLES E., MSC, USN.

BOWMAN, LT. COMDR. CLARENCE W., MSC, USN.

BROWN, CAPT. ERNEST H., USAF, (MSC).

CARSON, LT. COMDR. RALPH, MSC, USN.

CHIN, COMDR. YU-PIAO, MC, Chinese Navy.

CHRISTIANSON, 1ST LT. JAMES D., USAF, (MSC).

COMSTOCK, LT. MELVIN A., MSC, USN.

DEMPEWOLF, LT. EUGENE H., MSC, USN.

DEVANO, LT. (JG) JAMES J., MSC, USN.

DOBBS, LT. (JG) GEORGE I., MSC, USN.

ELLIOTT, LT. GORDON E., MSC, USN.

FORRESTER, LT. (JG) GEORGE G. JR., MSC, USN.

GILL, LT. ROBERT L., MSC, USN.

GOON, LT. (JG) MELVIN H., MSC, USN.

HARMON, 1ST LT. CHARLES C., USAF (MSC).

HARVEY, LT. DALLAS C., MSC, USN.

NAVAL SCHOOL OF HOSPITAL ADMINISTRATION graduates are, (from left) front row: Capt. Canio F. Palladino, USAF, MSC; Comdr. C. F. Crawford, MSC, USN (school commanding officer); Lt. Comdr. E. L. VanLandingham, MSC, USN (school executive officer); 1st Lt. James D. Christianson, USAF, MSC; Lt. (jg) Robert S. Ruffin, MSC, USN. Second row: Capt. William G. Humphreys, USAF, MSC; Lt. (jg) Russel L. Talley, MSC, USN; Capt. Russell M. Stoker, USAF, MSC; Capt. Ernest M. Brown, USAF, MSC; Lt. (jg) Chauncey C. Adams Jr., MSC, USN. Third row: Lt. (jg) Irwin O. Stallings, MSC, USN; 1st Lt. Frank R. Parsons Jr., USAF, MSC; Lt. Charles F. Welch, MSC, USN; 1st Lt. Billy F. Simmons, USAF, MSC; 1st Lt. Charles C. Harmon Jr., USAF, MSC. Not shown: Lt. (jg) Ellis W. Riser, MSC, USN, and Lt. (jg) Jay C. Smout, MSC, USN.

HOLCOMBE, LT. JOHN T., MSC, USN.

HUMPHREYS, CAPT. WILLIAM G., USAF, (MSC).

HUSSAIN, WARDMASTER LT. IQBAL, Pakistan Navy.

JANSON, LT. (JG) HAROLD J., MSC, USN.

JOHNSON, LT. CECIL R., MSC, USN.

LONG, LT. (JG) WILLIAM L., MSC, USN.

MAIELLO, CAPT. RICHARD F., USAF, (MSC).

MATEIK, LT. EDWARD D., MSC, USN.

NEUMAN, LT. (JG) RICHARD, MSC, USN.

PALLADINO, CAPT. CANIO F., USAF, (MSC).

PARSONS, 1ST LT. FRANK R., USAF, (MSC).

REED, LT. (JG) JOHN R., MSC, USN.

RICHARDSON, LT. (JG) JAMES W., MSC, USN.

RISER, LT. (JG) ELLIS W., MSC, USN.

ROWELL, LT. (JG) DALTON A., MSC, USN.

RUFFIN, LT. (JG) ROBERT S., MSC, USN.

SCHAFFNER, LT. (JG) LESLIE J., MSC, USN.

SHAFFER, LT. WELLER J. JR., MSC, USN.

SIMMONS, 1ST LT. BILLY F., USAF, (MSC).

SMOUT, LT. (JG) JAY C., MSC, USN.

STALLINGS, LT. (JG) IRVIN O., MSC, USN.

STOKER, CAPT. RUSSELL M., USAF, (MSC).

TALLEY, LT. (JG) RUSSEL L., MSC, USN.

TURNER, LT. (JG) DAVID H., MSC, USN.

VAN BUSKIRK, LT. (JG) FLOYD W., MSC, USN.

WELCH, LT. CHARLES F., MSC, USN.

WHETMORE, SUB LT. (mid) ROY H., Royal Canadian Navy.

ZALLER, LT. FRANK A., MSC, USN.

UNIVERSITY OF PITTSBURGH

Course director: Dr. John R. McGibony

ENGEL, ROBERT L., to Henry N. Hooper, administrator, Cincinnati (Ohio) General Hospital.

GREENE, OMAR V., to E. Atwood Jacobs, administrator, Reading (Pa.) Hospital.

HALL, PHILLIP J., to Dr. Anthony J. Borowski, administrator, Barberton (Ohio) Citizens Hospital.

HINKES, JULES M., to James McGuire, administrator, Western Pennsylvania Hospital, Pittsburgh.

HOLLIDAY, ROBERT L., to Maj. Robert C. Maybell, USAF, (MSC) director, Department of Administration, 3700th USAF Hospital, Lackland Air Force Base, Tex.

JASKOL, JOSEPH M., to Warren G. Rainier, director, Mountainside Hospital, Montclair, Pa.

MONACO, ANTHONY J., to J. L. McFarland, administrator, Harrisburg (Pa.) Polyclinic Hospital.

SNODGRASS, WILLIAM G. JR., to George R. Wren, director, Aultman Hospital, Canton, Ohio.

WEINSTEIN, BERNARD M., to Dr. Cecil G. Sheps, director, Beth Israel Hospital, Boston.

UNIVERSITY OF PITTSBURGH residents are, (from left) front row: Daniel L. Drosness (assistant professor in hospital administration); Charles R. Goulet (assistant professor in hospital administration); Dr. John R. McGibony (professor of hospital and medical administration); Phillip Hall; Bernard Weinstein; David Willis. Second row: Roger Klein (assistant professor in hospital administration); Robert Engel; Omar Greene; Dr. Carlos Zaldivar. Third row: Joseph Jaskol; Anthony Monaco; William Snodgrass, and Jules Hinkes.

WASHINGTON UNIVERSITY residents are, (from left) front row: Eugene Dahlgren; Stuart Ogren; Carroll Ogren; Dr. Frank R. Bradley (course director); Capt. Pearl Norberg; Osmund Webster; Donald J. Horsh; Kenneth Wicks. Second row: Harry E. Panhorst (associate course director); Capt. Donald Callaghan; Max Brabson; Charles Payne; Thomas J. Hartford Jr.; Charles M. Cliffe; Wade Henry, and Francis Fillingim.

WILLIS, DAVID P., to Dr. D. A. Clark, director, Massachusetts General Hospital, Boston.

ZALDIVAR, DR. CARLOS, to Charles R. Goulet, assistant professor in hospital administration, University of Pittsburgh.

WASHINGTON UNIVERSITY

Course director: Dr. Frank R. Bradley

BRABSON, MAX L., to Dr. J. A. Thrash, executive director, Medical Center, Columbus, Ga.

CLIFFE, CHARLES M., to David Endris, administrator, Youngstown (Ohio) Hospital Association.

CALLAGHAN, CAPT. DONALD, to Maj. Robert E. Maybell, preceptor, 3700th USAF Hospital, Lackland AFB, Tex.

DAHLGREN, EUGENE, to Bruce Dickson, administrator, Bethany Hospital, Kansas City, Kans.

FILLINGIM, FRANCIS, to Harry Piper, administrator, St. Luke's Hospital, St. Louis.

HARTFORD, THOMAS J. JR., to A. E. Hardgrove, administrator, Norton Memorial Infirmary, Louisville, Ky.

HENRY, WADE C., to Dr. Frank R. Bradley, director, Barnes Hospital, St. Louis.

NORBERG, CAPT. PEARL, to Dr. Frank R. Bradley, director, Barnes Hospital, St. Louis.

OGREN, CARROLL, to Clyde Fox, administrator, Washoe Medical Center, Reno, Nev.

OGREN, STUART, to Arthur Bailey, administrator, Orange Memorial Hospital, Orlando, Fla.

PAYNE, CHARLES, to Dr. John C. Mackenzie, administrator, Touro Infirmary, New Orleans.

WEBSTER, OSMUND, to W. L. Simon, administrator, East Tennessee Baptist Hospital, Knoxville.

WICKS, KENNETH D., to Dr. Allen Craig, administrator, Stanislaus County Hospital, Modesto, Calif.

YALE UNIVERSITY

Course director: George S. Buis

GIRARD, NORMAND E., to Robert L. Denholm, director, University of Colorado General Hospital, Denver.

HALLEN, PHILIP B., to Dr. J. Ewalt, commissioner, Massachusetts Department of Mental Health, Boston.

EDUARDO, DR. JIMENEZ ANZOLA, to Dr. A. C. Kerlikowske, director, University Hospital, Ann Arbor, Mich.

LEWIS, JOHN BOYD, to G. F. Stephans, administrator, Geisinger Memorial Hospital, Danville, Pa.

LIN, DR. CHI HSIEN, to Department of Public Health, Federal Government of Taiwan, Taipei.

MACDONALD, DR. THOMAS, to Ritz Heerman, director, Lutheran Hospital Society, Los Angeles.

NOROIAN, EDWARD, to Dr. T. Stewart Hamilton, director, Hartford (Conn.) Hospital.

SLATER, CRAIG S., to Lester E. Richwagen, administrator, Mary Fletcher Hospital, Burlington, Vt.

WEIL, THOMAS P., to Dr. Martin R. Steinberg, director, Mt. Sinai Hospital, New York City.

WOOD, ROBERT KENNETH, to Dr. Albert W. Snoke, director, Grace-New Haven (Conn.) Community Hospital.

YALE UNIVERSITY residents are, (from left) front row: John B. Lewis; John D. Thompson; George S. Buis (director of program); Dr. A. W. Snoke, director, Grace-New Haven (Conn.) Hospital; Dr. T. Glyne Williams. Second row: Dr. Chi Hsien Lin; Dr. Eduardo Anzola; Philip B. Hallen; Robert K. Wood; Craig S. Slater; Dr. Thomas MacDonald; Normand E. Girard; Edward Noroian, and Thomas P. Weil.

Disaster Log

Following is a list of disasters which affected hospitals, as reported to HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION.

Jan. 1; San Francisco; 100 firemen overcome by smoke in fighting a blaze were treated at Harbor, Central, and Mission Emergency hospitals.

Jan. 2; Savannah, Ga.; 39 patients were removed from 85-bed Charity Hospital when fire broke out there.

Jan. 16; Liberal, Kans.; 12 persons were injured in a gas explosion; 10 treated at 54-bed Epworth Hospital; 9 of the 10 were hospitalized.

Jan. 20; Milwaukee; 22 persons were injured in a Chicago and North Western Railroad train derailment; 8 were hospitalized at 950-bed Milwaukee County Hospital.

Jan. 29; Alameda, Calif.; 9 persons died and 44 were injured in a tanker explosion and fire; injured were taken to Kaiser Foundation Hospital, Providence Hospital, Samuel Merritt Hospital, and Highland-Alameda County Hospital, all Oakland, Calif.

Jan. 29: New Haven, Conn.; 5 persons were killed and 28 injured in garment factory fire; survivors were taken to 659-bed Grace-New Haven Community Hospital and to 370-bed Hospital of St. Raphael, both New Haven.

Jan. 29; Whiting, Ind.; 7 persons were injured in an explosion and fire at an oil refinery; injured were treated at refinery's hospital.

Feb. 1; Pacoima, Calif.; 7 children were killed and 74 injured when a transport plane crashed into a schoolyard after a mid-air collision; survivors were taken to 80-bed Valley Receiving Hospital, Van Nuys, Calif., and to 80-bed Sun Valley (Calif.) Hospital.

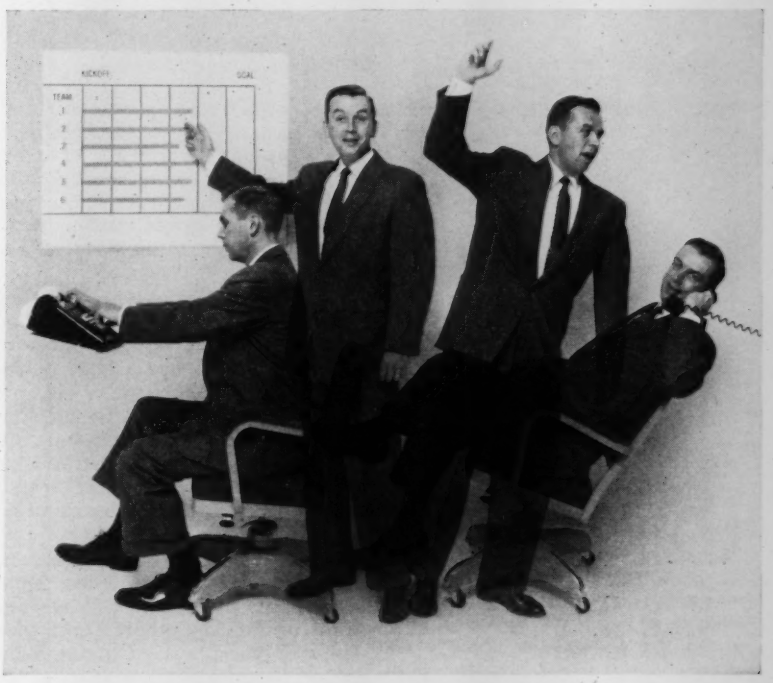
Feb. 1; New York City; 20 persons died and 82 were injured in the crash of a Northeast Airlines plane; disaster units from Bellevue, Metropolitan, and Queens General Hospitals were sent to the scene; injured were taken to various New York City hospitals.

Feb. 6; Reno, Nev.; 2 persons were killed and 61 injured in a gas explosion; 34 were treated at 260-bed Washoe County Medical Center, Reno; 7 were treated at 125-bed St. Mary's Hospital, Reno; 20 were taken care of in doctors' offices.

Feb. 13; Council Bluffs, Iowa; 14 died and 10 were injured in a fire at Council Bluffs Convalescent Home; 6 survivors were taken to 158-bed Jennie Edmundson Memorial Hospital and 4 were taken to 188-bed Mercy Hospital, both Council Bluffs.

Feb. 22; Mt. Airy, N. C.; one child died and 45-50 others were injured in a school fire; 12 were admitted to 371-bed North Carolina Baptist Hospital, Winston-Salem; 3 children were taken to 84-bed Hugh Chatham Memorial Hospital; 5 were taken to 9-bed Dobson (N. C.) Emergency Hospital; 25-30 other children were treated at the offices of Mt. Airy doctors.

Feb. 22; Pasadena, Tex.; one person died and 13 were injured in an explosion and fire at a paper plant; injured were taken to 45-bed Southmore Hospital and Clinic and 100-bed Pasadena Hospital and



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Clinic, both Pasadena; unknown number of injured were treated at the scene.

Feb. 27; Los Angeles; 37 persons were taken to Georgia Street Emergency Hospital following a trolley derailment; 7 of those injured were hospitalized at other municipal installations.

March 5; Kenosha, Wis.; boiler explosion at St. Catherine's Hospital critically injured the hospital's engineer and disrupted phone, laundry, and heating facilities.

March 7; Wilmington, Del.; 15 persons rescued after a ship collision in the Delaware River were treated at 377-bed Delaware Hospital; one person was hospitalized.

March 12; Gonzales, La.; 2 persons were injured seriously enough to require hospitalization at 250-bed Baton Rouge (La.) General Hospital after the crash of a bus into a car, approximately 25 miles south of Baton Rouge; 22 bus passengers were given routine physical checkups at the hospital and released.

March 13; Brooklyn, N.Y.; one man died and 11 persons were injured in a fire; the injured were treated at 253-bed Coney Island Hospital, Brooklyn.

March 16; Daytona Beach, Fla.; 16 persons injured in a train derailment were treated at 228-bed Halifax District Hospital; 4 of those injured required hospitalization.

March 18; Dearborn, Mich.; explosion and fire at Ford Motor Company plant killed 2 workers and injured 24 others; 7 of those injured were treated at the 6-bed plant hospital, 15 were hospitalized at 806-bed Henry Ford Hospital, Detroit, and 4 were hospitalized at 7,162-bed Wayne County General Hospital and Infirmary, Eloise, Mich.

March 19; Jacksonville, Fla.; 6 men died and 13 were injured when an elevator at a construction project fell 5 floors to the ground; the injured were taken to 335-bed Duval Medical Center, Jacksonville; some injured were later transferred to 215-bed St. Luke's Hospital and 302-bed Baptist Memorial Hospital, both Jacksonville.

March 20; Linden, N.J.; an explosion at the vitamin laboratory of Merck and Company killed 3 men and injured 11 others; one of the injured was hospitalized at 80-bed Rahway (N.J.) Hospital; others injured were treated at the plant dispensary.

March 22-25; San Francisco; all hospitals in the area were temporarily inconvenienced by a series of earthquakes which rocked the city.

March-April; blizzards in Colorado, Kansas, Oklahoma, Texas, and other midwestern states disrupted normal hospital operating schedules and caused a number of hospitals to institute emergency measures to cope with the unusual conditions.

April 2; Dallas, Tex.; 10 persons were killed and 193 were injured in a series of tornadoes; 178 victims were taken to Parkland Hospital; of these, one died and 33 required hospitalization; 14 other victims were taken to 288-bed Methodist Hospital of Dallas, 2 to 600-bed Baylor University Hospital, and one to 388-bed St. Paul's Hospital.

April 4; Sanatorium, Miss.; 25 persons at Mississippi State Sanatorium required surgical aid after a tornado struck the hospital; 4 of those hurt required hospitalization for their injuries; 25-30 other persons received minor injuries.

April 8; Michigan City, Ind.; 12 children were injured in a bus accident; the injured, 8 of whom required hospitalization, were treated at 54-bed Doctors Hospital and 100-bed St. Anthony Hospital.

April 11; Ellwood City, Pa.; 41 persons were treated for chlorine gas poisoning at 93-bed Ellwood City Hospital; 12 of those treated required further hospitalization; one other person was treated at 99-bed Beaver Valley General Hospital, New Brighton, Pa.

April 13; Montreal, Quebec, Canada; 16 persons died in a fire which swept a nursing home at Pointe aux Trembles, Montreal; 11 other persons escaped from the privately-owned home without injury.

April 16; Nitro, W. Va.; 5 workmen were killed and 6 injured in a chemical plant explosion; injured were treated at 150-bed Herbert J. Thomas Memorial Hospital, South Charleston, W. Va.; 12 others also were examined at the hospital.

April 17; Chicago; 28 children were sickened by escaping carbon monoxide gas; 6 were treated at 145-bed Holy Cross Hospital; one child was hospitalized.

April 19; Brooklyn, N. Y.; 63 subway passengers were injured in a collision; 40 of the injured required hospitalization.

April 24; Bloomington, Ind.; 12 persons were injured in a classroom explosion; 6 of the injured

were hospitalized at Bloomington Hospital.

April 27; Michigan City, Ind.; 12 persons were injured in a bus collision; 7 of the injured were hospitalized at 95-bed Fairview Hospital, La Porte, Ind.

April 30; Pittsburgh; 2 men were killed and 22 injured in a steel plant explosion; 18 of the injured were treated at the company's plant; 4 were sent to Western Pennsylvania Hospital, Pittsburgh, and McKeesport (Pa.) Hospital.

May 20; Kansas City; 37 persons were killed and upwards of 280 injured in a tornado; disaster plans were instituted at a minimum of 9 hospitals; heaviest influx of patients was at 330-bed Menorah Medical Center.

May 28; Chicago; 52 firemen were overcome by smoke; 11 of these were treated at nearby hospitals; the remainder were treated on the scene.

May 30; Libertyville, Ill.; more than 80 persons were stricken with food poisoning at a picnic; 45 were treated at 275-bed St. Therese's Hospital, Waukegan, Ill.; of the 45, 30 were hospitalized; 35 others were treated at 58-bed Condell Memorial Hospital, Libertyville, 14 of these being hospitalized; several other victims were treated at 118-bed Highland Park (Ill.) Hospital.

200 Insurance Companies Use Uniform Claim Forms

More than 200 insurance companies are using uniform hospital insurance forms to simplify the processing of accident and sickness claims, the Health Insurance Council has reported. The forms, one for group hospitalization claims and the other for individual hospitalization insurance claims, were developed by the council.

The Board of Trustees of the American Hospital Association and the Council on Medical Service of the American Medical Association have approved use of the forms.

According to HIC, the firms using the uniform forms write more than 80 per cent of the group accident and health insurance and more than 50 per cent of the individual and family protection provided by the health insurance business.

Committees are the best framework for getting medical staff work done

(Continued from page 36)

tions encountered in this study is in a 55-bed hospital having 16 active, 15 courtesy, 13 consultant and 4 honorary members. The staff elects an executive committee of 5 members and has 8 other standing committees. The executive committee meets monthly one week prior to staff meetings. All committee reports and recommendations are referred to them as are problems relating to the administration of the hospital. The executive committee's decisions on any matter are final and are read to the staff at their monthly meeting. Objections to their decisions cannot be made from the floor but must be made later in person to the executive committee. ■

The board and the administrator: spelling out their relationship

(Continued from page 44)

policy decision—how it was implemented, how it was received, and how it might be improved.

To keep the other party well informed (and it works both ways, from board to administrator as well as vice versa) a portion of each

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board meeting should be reserved for a report or review of operational problems not necessarily requiring action at the time. A briefing now will save time and ease the decision process later, for eventually every major function will require board attention. At what point the nature of the presentation ceases to be informative and becomes educational is of little importance. Any approach that enhances the ability to make sound decisions is justified.

Other opportunities for mutual information exchange are committee meetings, contacts with individual board members between formal meetings, literature handed out or mailed including published journals and periodicals, monthly "news" letters, occasional special meetings which the administrator conducts, and through written progress reports. ■

A new concept of the medical audit

(Continued from page 51)

pitals and those in large hospitals. It is also apparent from the proportions of criticisms, which did not differ greatly among the various hospital groups, that the physicians in each hospital group felt that their own uses of anticoagulants were appropriate. This probably reflects differences in philosophies of medical practice, and it should stimulate physicians in these participating hospitals to review the most recent information concerning indications and contraindications of the use of anticoagulants in myocardial infarction.

Medicine is a most dynamic and exacting profession; scientific advances occur constantly and with such rapidity that the conscientious physician must necessarily engage in continuing postgraduate education throughout his entire professional career. The physician must study, observe, and draw his own conclusions by comparing the experiences of other physicians with his own experiences in the practice of medicine.

The college's audit method provides a mechanism by which the physician may obtain with a minimum of effort accurate information about his own care of patients and may compare his care with that given by other physicians. This provides continuing postgraduate education for the physician, elevates the standards of patient care, and increases the welfare of patients. ■

Role of the medical staff

(Continued from page 56)

locates the casualties, it notifies the dispatcher at the receiving center, who gives the instructions to the ambulance driver. If medical attention is needed at once, a doctor accompanies the ambulance.

The director of nurses should be in contact, by field telephone, with the receiving center, from where she is advised of the extent and nature of the casualties being received. She also should obtain information as to the availability of additional nurses and volunteer aides.

In order to reserve the hospital for the critically injured, a transfer center, previously set aside, should be provided. This makes possible the transfer from the hospital of such patients as can be moved and also provides a place where minor casualties can be sent after treatment at the receiving center.

Whether in the day-to-day emergency services of the hospital or in an expanded service for mass casualties, the role of the medical staff determines the quality and the effectiveness of the emergency service rendered by the hospital. ■

Divided duties demand unified plant layout

(Continued from page 53)

questions which may have developed since her last visit.

In our hospital the manager of the dietary department does her own purchasing. In many hospitals of similar size, however, the administrator—who generally is also the purchasing agent—purchases food as well.

NURSING SERVICE

Nursing in a small hospital has many compensations not found in larger institutions. The opportunity of getting to know the patient as a person rather than a bed or room number can be very rewarding to both the nurse and the patient. The therapeutic value of the "family" atmosphere which prevails not only in the nursing department but throughout a small hospital is great.

Our nursing service consists of the director of nurses, 15 nurses and 17 nurse's aides. The director of nurses also serves as floor supervisor, scrub nurse, obstetrical supervisor, etc., depending on the current needs of the hospital.

Problems requiring additional nursing assistance, such as an influx of patients to the accident room or overcrowding of a particular floor, are resolved by juggling of personnel by the director of nurses, since there are so few people covering the entire service.

In addition to regular nursing duties, a nurse in a small hospital is also required to provide training for inexperienced personnel such as nurse's aides who, when obtained from the available local area, require extensive training similar to that given in organized programs by larger institutions.

PHARMACY DEPARTMENT

The pharmacy in a small hospital is usually not a pharmacy in the technical sense but a drug storeroom from which the stock is distributed to the floors. Our pharmacy is maintained by the director of nurses and carries an inventory of approximately $3,000.

All prescriptions are compounded by a local pharmacy and all drugs are purchased by the hospital at cost from this pharmacy. This convenient arrangement is a timesaver for the "purchasing-agent administrator" since it eliminates the time which would otherwise be spent with drug salesmen. Through quantity purchases, the local pharmacy is also able to obtain better prices on some items than the hospital would normally get.

The operation of a small hospital offers a challenge to the ingenuity of everyone associated with it. The advantages of working closely on a "first name" basis with everyone in the organization and the knowledge gained from having to learn about most of the jobs in the hospital are invaluable.

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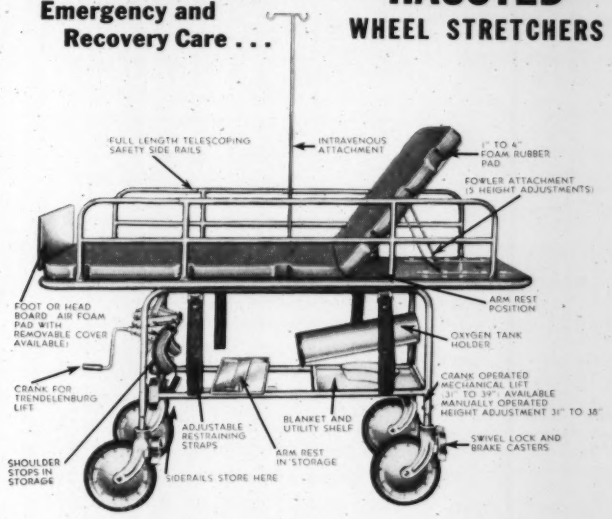
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how hospitals are reducing mattress costs

Ordinary mattresses have always been a problem of inconvenience and expense. They are easily soiled and difficult to clean and sanitize. If they are protected by rubber or plastic sheets, both operating costs and patient discomfort are increased. Hospitals and Institutions all over the country are now reporting that a revolutionary new mattress named SYKO-ETTE has eliminated these problems.

The most important advancement is in the SYKO-ETTE covering material which is made of a special weave nylon, impregnated and coated with a special neoprene compound. The result is a mattress that is completely waterproof, fire resistant, and non-irritating to the skin. Makes an ideal mattress for use on gatch beds, pliable but does not stretch out of shape.

When a SYKO-ETTE Mattress is soiled, it is easily and quickly scrubbed with soap and water, and wiped dry for immediate re-use. The need for rubber or plastic sheets, with their cost, bother, and discomfort to patients, is eliminated. SYKO-ETTE Mattresses outlast all others, save the replacement cost of three to five of any other type. Mattress inventory can be reduced.

Furthermore, the SYKO-ETTE Mattress is unsurpassed for comfort. The sleeping surface is perfectly smooth—no buttons, no humps, no sagging. Sheets do not crawl or wrinkle under the patient's body, protects against bedsores. Beds do not require re-making as often, thereby saving time of nurses for more important duties.

Three types of inner construction are available, including rubberized hair pad with stitched cotton felt, Foamex rubber with center stiffener pad, and a specially designed innerspring unit. All have SYKO-ETTE covering material.

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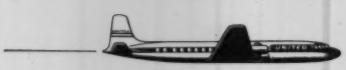

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Hospital association meetings

(Continued from page 6)

AHA INSTITUTES

(THROUGH DECEMBER 1957)

Dietary Department Administration — August 5-9; Los Angeles (Ambassador Hotel)

Hospital Pharmacy—August 19-23; Chicago (University of Chicago)

"Staffing" (Nursing) Department Institute — September 23-26; New York City (Sheraton-McAlpin Hotel)

Operating Room Administration — October 7-10; Kansas City, Mo. (President Hotel)

Insurance for Hospitals—October 9-11; Hartford, Conn. (Statler Hotel)

Methods Improvement Workshop—October 14-18; Augusta, Ga. (Bon-Air Hotel)

Medical Record Library Personnel—October 21-23; Albuquerque, N. Mex. (Hilton Hotel)

Disaster Planning—October 30-November 1; Jacksonville, Fla. (George Washington Hotel)

Evening and Night Nursing Service Administration Institute — October 28-November 1; Riverside, Calif. (Mission Inn)

Hospital Auxiliary Leadership—November 4-5; Hartford, Conn. (Statler Hotel)

Hospital Organization Planning Workshop — November 4-8; Los Angeles (Ambassador Hotel)

Physical Therapy—November 4-8; Boston (Somerset Hotel)

Housekeeping—November 11-15; Toronto, Canada (King Edward Hotel)

Nursing Service Administration—November 11-15; Honolulu, Hawaii (Princess Kaiulani)

Medical Record Library Personnel — November 11-15; Boston (Sheraton-Plaza Hotel)

Operating Problems for Small Hospitals —November 14-15; Saskatoon, Canada (Bessborough Hotel)

Seventh Hospital Institute — November 18-22; Honolulu, Hawaii (Princess Kaiulani)

Hospital Safety Seminar—November 18-22; Chicago (Congress Hotel)

Hidden assets of accreditation

(Continued from page 39)

tired of fighting doctors to keep the hospital up to par." It would seem that many physicians and staffs are failing to carry their fair share of the burden in keeping standards high. Perhaps this is an area of activity to which the AMA and state and county medical societies could well devote some attention. It is the author's personal opinion that doctors practicing in a one-hospital community have a greater moral obligation to support accreditation than their big city colleagues whose patients have a wide choice of hospital facilities.

CONCLUSIONS

Results of the survey create the impression that administrators of small hospitals are as much concerned with hospital accreditation as are their larger neighbors. Further, the standards are more difficult to attain in small hospitals. For the most part, there is little that can be done to make accreditation easier to achieve in small hospitals.

In general, administrators surveyed feel that the joint commission is doing a valuable job—and doing it impartially and well. However, two suggestions made frequently seem worthy of thought and action: some administrators believe (1) that the joint commission should give more attention to the medical record difficulties faced by small hospitals without interns or residents and (2) that the medical societies should take a more active role in persuading their membership of the physicians' responsibility for meeting accreditation standards. ■

Opinions and ideas

(Continued from page 22)

bottom of each page lists the divisions on each floor with the corresponding number.

An alphabetical list of 225 specific services is provided with reference to the assigned numerical figure and the page on which the plan will be found. Distribution of the 1,541 beds among the various medical services is also given in terms of services to be continued in the existing buildings and those assigned to the new building.

The administrative staff believes that this booklet will help keep the staff better informed and an informed employee group, representing all walks of life, can be a great asset in interpreting hospital services to the public.—KENNETH J. SHOULDICE, *administrative assistant, Milwaukee (Wis.) County Hospital.* ■

prn

PRO RE NATA

JOHN H. HAYES

An advertisement in the Michigan Business Women's Bulletin states: "If you've married, moved or died, please let us know." I suppose this could be done by Heir Mail.

★ ★ ★

The most promising public relations program for a hospital is that which begins with a good personnel program.

★ ★ ★

Some people consider a community chest as a means of being charitable at wholesale prices.

★ ★ ★

There will come the time when a hospital will be able to print on its letterhead "President ..... was born here"; but will probably hesitate to do so because it might alienate financial support of either Republicans or Democrats.

★ ★ ★

Would you call a red headed nurse in a nylon uniform a static Titian? Or a physician with laryngitis a hoarse doctor?

★ ★ ★

Most of our worries are about things that could happen; but seldom do.

★ ★ ★

My crack-brain friend, Pat Pending is working on a new one: A thermostatically conductive hospital bed sheet that will continuously record the patient's temperature, with an alarm arrangement that will go off at 103° F.

★ ★ ★

Not too long ago people had large families as a means of providing Old Age and Survivors Insurance. That seemed to work out quite well. Nowadays people have small families, live longer; and Uncle Sam has taken over the responsibilities of the children.

Perhaps the best Old Age Insurance is clean living. But they say that the good die young.

Nothing ever seems to get solved in this column.

★ ★ ★

HOSPITAL DEFINITIONS:

ACCOUNTS RECEIVABLE: An overestimate of what you might collect.

MEANS TEST: A quiz program in which even the wrong answers are accepted.

X-RAY LABORATORY: The Department of the Interior.

MEDICAL CONSULTATION: A discussion of baseball in the summer and the weather in winter.

CAPSULE: A pill in a raincoat.

★ ★ ★

This really happened: A newspaper, in publishing the winners of prizes at a nurses' commencement, listed the winner of the pediatrics prize as earning it in "Care of the feet".

★ ★ ★

It could be that the reason why few doctors ever run for public office is that doctors realize that voters do not vote for people to whom they owe money.

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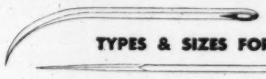

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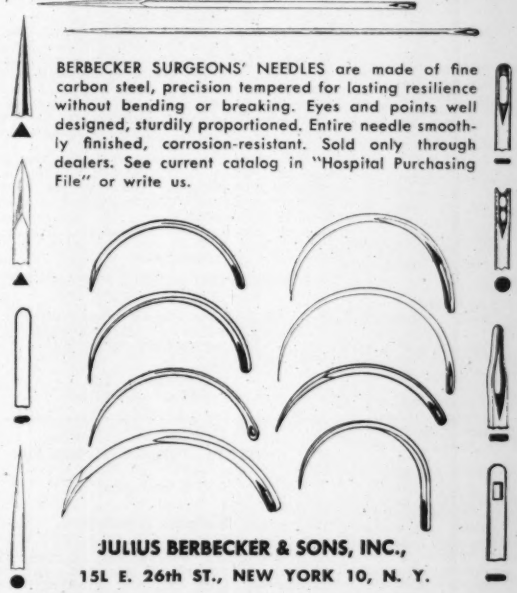

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Two REGISTERED NURSE ANESTHETISTS for 86 bed general hospital. Good working conditions and good personnel policies. Salary open. Write, phone, or wire: Casper F. Paulson, Administrator, Columbia Hospital, 16th at Franklin Street, Astoria, Oregon.

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DIRECTOR OF NURSES: 80 bed general hospital fully accredited by the Joint Commission on Accreditation of Hospitals. Salary open. Excellent personnel policies and employees benefits. Experience and degree preferred. Address HOSPITALS, Box H-63.

Pekin Public Hospital, Pekin, Illinois is desirous of obtaining applications from qualified administrators for appointment September 1, 1957. Write: Mr. Paul T. Soldwedel, Chairman, Personnel Committee.

ASSISTANT DIETITIAN: 375 bed general hospital. Duties involve therapeutic diet planning, patient contact and general supervision. Salary open. Full employee benefits. Apply: Director of Personnel, Blodgett Memorial Hospital, Grand Rapids, Michigan.

DIRECTOR — NURSING SERVICE AND EDUCATION: 300 bed general hospital, with 150-student school of nursing, and expansion program in progress, needs Director of Nursing to be responsible for Nursing Service and School of Nursing. Applicants should be in excellent health, between approximate ages of 35-45 and of Protestant faith. Liberal salary range and employee benefits. Excellent working conditions in one of Midwest's foremost institutions, centrally located in city and convenient to outstanding residential and shopping facilities. Contact, Personnel Director, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

OPERATING ROOM NURSES desirous of career in 450 JCAH bed hospital offering personnel prequisites, opportunity of working with large staff of surgical specialists; cafeteria; nationally approved School of Nursing, new modern surgeries and hospital. Phone or write Good Samaritan Hospital, Employment Recruiter's Office, 1015 N.W. 22nd Avenue, Portland 10, Oregon. Phone CApital 3-3171, ext. 255.

GRADUATE NURSES, NURSE ANESTHETIST, LAB. TECH., X-RAY TECH., OR COMBINATION LAB.-X-RAY TECH., MED. REC. LIBRARIAN, DIETITIAN, COMBINATION ADMITTING CLERK-BKPR-SECRETARY. Top salaries outside Federal hospitals, 40-hr. wk., progressive personnel policies. New Hosp. opened Jan., 1957. Rocky Mtn. region, 25-min. drive to mtn. scenery, fishing, hunting, picnic grounds, not far from Natl. park. Address: HOSPITALS, Box H-57.

THERAPEUTIC DIETITIAN, MEDICAL RECORDS LIBRARIAN, CHIEF PHYSICAL THERAPIST needed immediately. Salary open, ideal working conditions, ultra modern 220 bed hospital, beautiful location. Dept's must be seen to be appreciated. Contact H. H. Hill, Administrator. Weld County General Hospital, Greeley, Colorado.

LIBRARIAN, MEDICAL RECORD—Registered. To assume charge of record room. 135 bed general hospital, 40 hours—salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland, Ohio.

LIBRARIAN, MEDICAL RECORD, REGISTERED, to assume charge of record room, 85 bed hospital. Good policies, salary open. Contact Administrator, Kalispell General Hospital, Kalispell, Montana.

EDUCATIONAL DIRECTOR: for accredited diploma school of nursing; 270 beds modern, accredited, general hospital and teaching institution for interns, residents, x-ray and laboratory technicians. School affiliation with Oberlin College and Metropolitan City Hospital for specialties. Rapidly expanding community near universities. Excellent personnel policies. Salary commensurate to degree and experience. Write Director of Nursing, Elyria Memorial Hospital, Elyria, Ohio.

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Chicago 11, Illinois

ADMINISTRATORS: (a) Ass't med. director; 450-bed hosp; interesting city outside US; delightfully equable climate. (b) Adm. to succeed adm. retiring after 22 yrs; gen. 250-bed hosp; univ. city, W. (c) Ass't; 350-bed hosp. adjacent to univ. campus; So. (d) Ass't; pref. with accounting exp; gen. hosp., 200 beds; univ. city, E. NURSE ADMINISTRATORS: (e) New gen. hosp. under construction; 50 beds; E. (f) Children's hosp; 60 beds; leading oil center, SW. H7-1

ANESTHETISTS: (a) Well estab. anes. group; coll. town, MW; to $8400. (b) Chief; 4 nurses, 4 M.Ds on staff; lge gen. hosp; most ideal So. Fla. resort city; $6000 up. (c) Staff; gen. hosp. Hawaiian Is; near beaches; to $5700, transportation arrgmt. H7-2

DIETITIANS: (a) Chief; 500-bed hosp; ability re-organize; uni. city, MW; $6000 up. (b) Chief; 400-bed hosp; Greater Manhattan NY area; month vacation; top sal. H7-3

DIRECTORS OF NURSING: (a) Dir. nursing, small hosp. Latin America; ability speak Spanish moderately $6000, mtce. (b) Dir. service & school; univ. affil. 500 bed hosp. with expansion program; near NYC; $10,000. (c) Dir. of nurses; brand new air conditioned hosp. 40 beds; Mexican border; good sal. (d) Dir. nursing service; reorganization expansion prog; outstanding oppor. for capable executive nurse, $7000, San Francisco area. H7-4

EXECUTIVE HOUSEKEEPERS: (a) Man or woman; 200-bed new hosp; univ. town, So; $5400. (b) Small co-ed coll; supervise staff, mtce, student res. halls; MW. H7-5

EXECUTIVE PERSONNEL: (a) Business mgr; strong accounting exp; 400-bed tchg hosp; MW. (b) Comptroller; 200-bed hosp; resort, coll. town, W. (c) Executive sec'y; med. society; W. (d) Public relations & personnel dir; 200-bed hosp; E. (e) Food service dir; newly created position; 600 beds; E. H7-6

FACULTY POSTS: (a) Med.-surg. instructor; new 4-yr coll. program; W. mountains; $455 month academic yr. (b) Ped., med.-surg., collegiate school; tch'g only; N. Calif; $5100-$7600. (c) Chairman, nursing educ. program, state coll; $8000. (d) Psy., pub. health, ped. instructors; faculty status; $6000-$7200; SW. H7-7

MEDICAL RECORD LIBRARIANS: (a) Dir-Instructor; school for med. records librarians; outstanding oppor; progressive city; SW. (b) Chief; new position; reorg. of ocean city hosp; wealthy Calif. community; Sal. commensurate ability. H7-8

STAFF NURSES: (a) Foreign assignment; outstanding American co; air-conditioned hosp., living quarters; employee golf, tennis, swimming; $8400, paid air travel. H7-9

SUPERVISORS: (a) Psy. in-serv. for professional nurses, P.N., aides; estab. prog; $5000; near Wash., D.C. (b) EENT & psy; 900-bed hosp; univ. center; $5200-$5500; MW. (c) Operating room, ped; 450-bed hosp., leading manufacturing city, near Lake Mich. summer resort, $5000. (d) Operating room, capable assuming direction nursing serv; excell. oppor; 40-bed new air-conditioned hsp., Texas; $5000. H7-10

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ADMINISTRATORS: (a) Need one w/coll degree or equiv to supervise two hosps; salary range $9,600-$15,000; MW. (c) Adm; experienced; to take full charg in equipping, planning, and supervising installation of new 1,000 bed hosp—also maintenance; Venezuela. (d) 175 bd genl JCAH hosp; excel Board and staff; req's one with ACHA affiliation; Central; $12,000. (e) Req's one with degree; 125 bd genl hosp; $8,000; E.

ASSISTANT ADMINISTRATORS: (a) Asst; vol genl hosp, 225 bds; tchg prog; about $8,000; lge city on Lake Mich; (b) Pref young man with MHA degree—exper unnecessary; 100 bd hosp, expanding to 200, modern & deluxe; nr Chgo; $6,000. (c) 150 bd hosp, doubling capacity; req's degree and exper; $10-12,000; MidE. (d) Asst Service dir; req's MHA, very large hosp; tchg prog; $7200-9000; E. (e) Fully approv'd 400 bd vol genl hosp; lge city on Great Lakes. (f) Must have Hosp deg and 2 yrs exper; 165 bd hosp; $6,000; MW.

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55 East Washington Street

Chicago 2, Ill.

Blanche L. Shay, Director

ADMINISTRATIVE PERSONNEL: (a) Superintendent. Middle West. Good business background. 190 bed hospital. To $10,500. (b) Ass't. Superintendent. East-large hospital. $7000. (c) Ass't. Administrator. 150 bed hospital in a middle west town of about 25,000. Man or woman. $5400. (d) Personnel Director. Middle West. Qualified to set up dept, in large hospital. (e) Ass't. Administrator. South. 350 hospital. Chief duties: personnel and purchasing. To $7800. (f) Public Relations Director. East. 400 bed hospital. $5000.

DIRECTOR OF NURSES: (a) East. Assistant Administrator. 100 bed hospital. Must be R.N. with degree. (b) East. 400 bed hospital affiliated with medical school. To tal. (e) Ass't. Administrator. South 350 bed $10,000. (c) New England. 220 bed hospital in city of 80,000. $7200 plus maintenance. (d) Assistant. 325 bed hospital. B.S degree. Very responsible position — good future. City of 100,000. $5000. (e) Northwest. 200 bed hospital, fully approved. Collegiate School of Nursing. $6000 minimum.

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CHIEF MEDICAL RECORD LIBRARIAN. For 140 general hospital. 35 miles from New York City. Expansion program underway. Excellent personnel policies. Apply Director, Middlesex General Hospital, New Brunswick, New Jersey.

Wanted—RRL for accredited general hospital of 200 beds. Salary open. Apply Audrey Shade R.N., Administrator, St. Luke's Hospital, Marguette, Michigan.

EDUCATIONAL DIRECTOR—male or female, needed immediately. J.C.A.H. hospital 130-bed, 25 bassinets, 60 students in temporarily accredited school of nursing. Starting salary, $400.00. Theodore F. Kaap, Jr., Administrator, Mennonite Hospital, 807 North Main Street, Bloomington, Illinois.

ADMINISTRATOR IN NURSING—Master's degree—Experienced in Nursing Education and Nursing Service, 300 bed Hospital School of Nursing, salary open varying with qualifications. Address HOSPITALS, Box H-66.

CHIEF DIETITIAN—Experienced dietitian wanted, capable of assuming complete responsibility for Dietary Department of 500-bed General Hospital, located 90 miles from New York City, 55 miles from Philadelphia. ADA preferred but not essential. For further information write HOSPITALS, Box H-67.

CHIEF DIETITIAN—a challenging position. We are seeking an unusually competent person who has an excellent record in planning and directing a Dietary Department. This is one of the more progressive hospital organizations in the midwest, with a capacity of 315 beds. The facilities are new and modern, and salary is open and commensurate with ability and experience. Submit a complete resume of age, education, experience, and present salary. Address HOSPITALS, Box H-68.

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PEDIATRIC TEACHING SUPERVISOR: Degree and pediatric experience required. 425 bed general hospital, 50 bed capacity in pediatric division. Administrative and teaching responsibilities. Salary commensurate with qualifications and experience. Apply Director of Nursing, Queen's Hospital, Honolulu, T.H.

OPERATING ROOM NURSE—Some positions available in the system of 10 general Hospitals of Miners Memorial Hospital Association. Hospitals are one year old, well equipped. Supervisory experience required. Salary at the rate of $6420. per annum for a 40-hour week. Benefits include: 4 wks paid vacation, 7 paid holidays, non-contributory hospitalization-health and retirement plan. Telephone or write: Miners Memorial Hospital Association, P.O. Box 61—Telephone 494, Williamson, West Virginia.

MEDICAL RECORDS LIBRARIAN—Registered or eligible for registration to Head the Department in a 500 bed Tuberculosis Hospital. Liberal holidays, vacations, sick leave benefits and pension plan. Apply Medical Director, P.O. Box 1411, Lantana, Florida.

ANESTHETIST-NURSE. For 250 bed general hospital. Excellent working conditions and personnel policies. Good starting salary. Write: Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 N. Maryland Avenue, Milwaukee 11, Wisconsin.

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Outstanding opportunities for qualified SUPERVISORS in OBSTETRIC and PSYCHIATRY and CLINICAL SUPERVISORS. 400 bed hospital, approved Intern-Resident program; school of nursing accredited. Excellent beginning salary, pension plan, group life insurance, four weeks vacation, apply Personnel Director-Christ Hospital, Cincinnati, Ohio.

LIBRARIAN, MEDICAL RECORDS: Registered or eligible for registration to head department at 500 bed fully accredited teaching hospital. Salary $4400-5527; excellent holiday, vacation, sick leave benefits; free life and health insurance. Write Personnel Officer, PGH-Northern Division, 151 W. Luzerne St., Philadelphia 40.

POSITIONS WANTED

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M. Burneice Larson—Director

900 North Michigan Ave.

Chicago 11, Illinois

ADMINISTRATOR: Med; M.P.H. (Yale); 8 yrs, ass't supt., 1200-bed gen. hosp; 3 yrs, adm staff, one of leading org. in grad. med.

ADMINISTRATOR; M.H.A; 4 yrs, assoc. dir, tch'g hosp., assisting in bldg., prog. increasing capacity from 200 to 400; 6 yrs, dir., 225-bed hosp.

ASSISTANT ADMINISTRATOR: B.S. (Bus. Adm); M.H.A; since completing res., tch'g hosp., personnel dir., instructor, Prog. in Hsp. Adm.

FOOD SUPERVISOR: B.S. (Major: Institutional Management and Home Economics); 10 yrs' exp.

PATHOLOGIST; M. S. (Path.); Diplomate (Path. Anatomy, Clin. Path); 8 yrs, dir. path., 250-bed hosp.

RADIOLOGIST; M. S. (Radiology); 4 yrs, group assn; Diplomate.

POSITIONS WANTED

ADMINISTRATOR: 9 years, 250 bed general hospital. Chief accountant, administrative assistant, 4 years assistant. Experience includes planning, equipping, staffing new hospital, NACHA, 34. Address HOSPITALS, Box H-14.

DIRECTOR, Asst. Director Nursing Service B.S., M.A., varied experience, send details, HOSPITALS, Box H-64.

Combination position of CHIEF PHARMACIST and ASSISTANT ADMINISTRATOR for 150-200 bed hospital. Four years experience as Chief Pharmacist in a 200 bed hospital, Prefer Virginia, Tennessee, Kentucky, or South East. Address HOSPITALS, Box H-30.

OUR 61st YEAR

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• ANN WOODWARD • Director

ADMINISTRATOR: B.S. (bus adm), M.S. (hosp adm) 5 yrs, hosp acctng, ofc & cred manager, 150 bd hosp; 18 mo, ass't dir, 1000 bd tchg hosp; any locality; early 30's; Nominee ACHA.

ASSISTANT ADMINISTRATOR: B.S. (bus adm) M.S. (hosp adm); yr's res, 600 bd hosp; 3 yrs, exper as asst adm then adm, 450 bd hosp; consider asstshp, univ affil hosp very lge size; middle 30's; excel ref; Nominee ACHA.

PATHOLOGIST: 7 yrs, dir, path, 200 bd hosp; Dipl, anatomy & clinical; prefs North-south Atlantic states.

RADIOLOGIST: 1 yr, Fellow & instructor, impor univ cancer research hosp; 14 mo, research asst, rad therapy, tchg hosp; qual, supervoltage therapy; prefers rad therapy under academic circumstances; or hosp rad (diagnosis, therapy) pref with priv pract; early 30's; Dipl, diagnostic, therapy.

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HOSPITALS

Journal of the American Hospital Association

18 East Division Street, Chicago 10, Illinois

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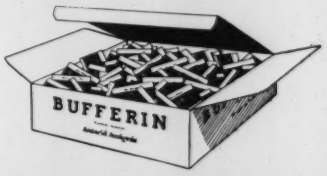

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